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**Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245*
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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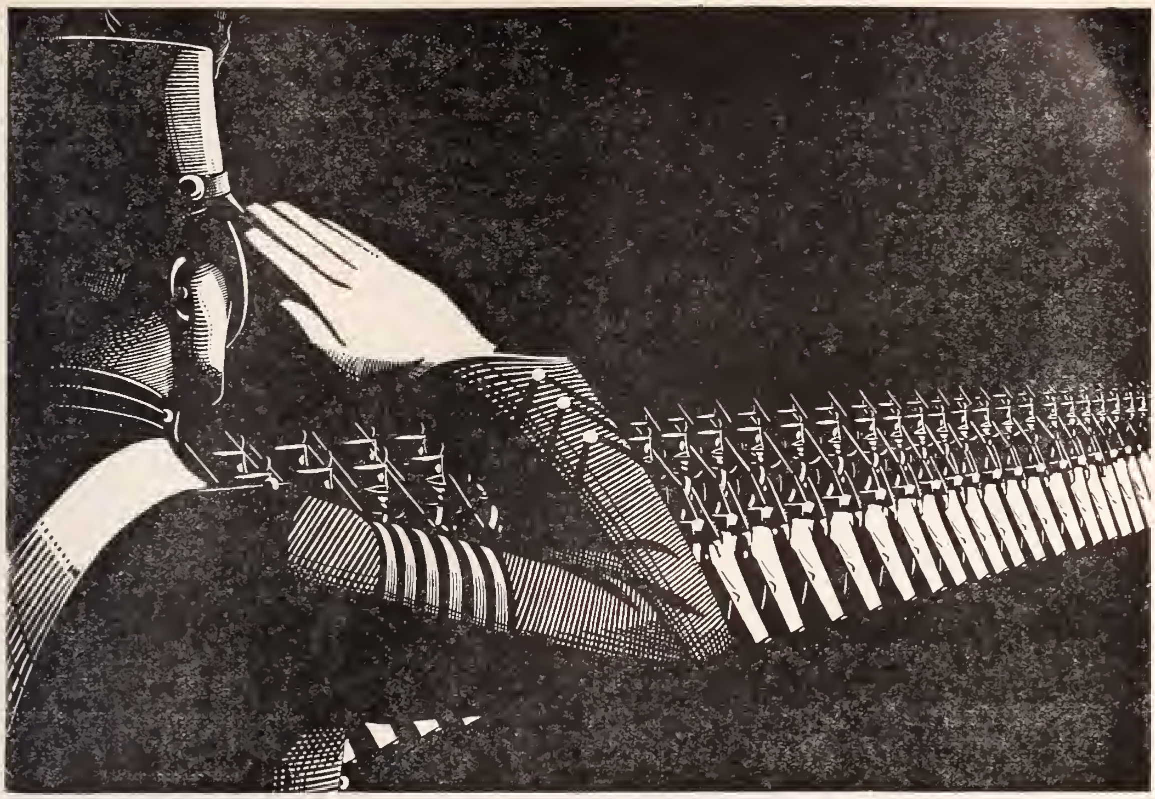

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It is difficult to estimate the frequency of mild vitamin B_1 deficiencies in the United States. However, until such information is at hand, it is not illogical to suggest that latent avitaminosis B_1 must be regarded as an active possibility in some cases which may come to the attention of the medical practitioner. Fortunately, several factors are operative which give assurance that eventually the incidence of latent avitaminosis B_1 will be reduced to a minimum.

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1a. 1935. J. Am. Med. Assn. 105, 1580.
b. 1934. The Vitamin B Requirement of Man, G. R. Cowgill, The Yale University Press, New Haven.

2. 1937. J. Am. Diet. Assn. 13, 195.

3. 1936. J. Nutrition 11, 383.
1934. Ibid. 8, 449.
1932. Ibid. 5, 307.
1932. Ind. Eng. Chem. 24, 457

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Maine Medical Journal

The Official Organ of

The State and County Medical Societies

Vol. XXIX *Portland, Maine, January, 1938* *No. 1*

Graduate Medical Education in Maine

By Frederick T. Hill, M. D., Waterville, Maine

One of the greatest problems facing organized Medicine today is that of providing an adequate program of Graduate Education for the Profession. Medicine is not an exact Science, for it deals with the afflictions of one of the most variegated unstable of species, Homo sapiens. New discoveries, results of researches, are constantly bringing about changes in our methods of handling disease, so that what one has once learned in medical school often becomes little more than basic training as years go on. Backed up by experience and by common sense, this may enable one to provide very fair medical care in many instances, but the practitioner thus limited is working under a distinct handicap. This is in decided contrast to the progressive physician who is constantly endeavoring to keep himself abreast of the Times. If we as a Profession are to provide the Public with adequate Medical Care, we must see to it that we are equipped to do so. This means a program of continued Education upon our part, constant study, contemporary reading, and thorough conception of the most modern methods of diagnosis and treatment. By this means only, is the Future of Medicine in our own hands.

The conscientious practitioner should subscribe to several medical journals of National scope, in addition to his State Journal, and should read them consistently. Limiting one's supply of medical periodicals is truly false economy, for if these journals are used as they should be, and not merely allowed to collect dust, they may serve as very useful and inexpensive sources of scientific information.

He should faithfully attend the meetings of his County and State Societies and insist that instructive, interesting programs be provided. These meetings should be primarily educational. If a high standard of program is maintained, they form one of the best examples of group education.

Group instruction by means of the hospital staff meeting provides one of the finest means of graduate education. Careful analyses of the clinical work of the hospital staff is extremely worth while. This can be developed into a real system of case study and, if discussions be made frank and open, cannot help but be most valuable and instructive. It is the hope of the Committee on Graduate Education that each of our hospitals will hold at least monthly meetings, based upon this idea of case study, and that physicians throughout the State will develop the habit of regularly attending at one of these meetings. *(Pick out the most convenient hospital which provides a good program. Never mind whether you are a staff member or not. If not, you will soon be, if you attend these meetings. And if good programs are not already provided, use your endeavors to see that they are. The material is there. It may just need developing.)*

Last year a beginning in extension programs was made, when a three-day program in Pediatrics and Obstetrics was made available for our County Societies. This has been used a number of times in different localities and has proven its value. Other extension programs are now in the process of development. It is the hope of our committee that each standing committee of the State Association will work up a program covering their field which may be available to any County Society. Looking still further ahead, the committee has in mind to inaugurate a system of graduate lectures, basic in character but bringing out the latest in Medicine, which would be given in various centers of the State, by different authorities on each subject. The idea would be to have each lecturer appear in a different place each evening of a week, and then follow the next week with a different subject and lecturer. In this way one locality would have, for example, a lecture each Monday night for a period of perhaps eight weeks. The same course would be repeated in a neighboring locality on Tuesday nights. Centers convenient for a majority of our physicians could be selected and thus a fairly comprehensive postgraduate course could be made easily available. This can be done if sufficient interest be manifested on the part of our physicians.

One of the best means of keeping up Graduate Education is by attendance at the meetings of the various National Medical Societies. The very latest advances in Medicine are presented on these programs and the ensuing discussions are bound to bring out a great deal of value. Naturally this is quite superior to merely reading the published article, when the discussion and general reception of the paper may be entirely missed. Unfortunately too few physicians make a practice of attending these meetings. This may be due to an erroneous idea that these meetings are limited to the membership of the societies. The Profession is cordially invited to all these meetings and more should avail themselves of this privilege. It would prove a most stimulating experience and, once inoculated, the habit of attendance would be readily acquired.

Many of our physicians are so situated that they cannot readily avail themselves of opportunities for Graduate Education. Many of them have no hospital staff connections, or their hospital facilities may be insufficient to provide for group study. Many of them have been truly laboring in the Lord's Vineyard, at small recompense, other than the affection and regard of their patients and the knowledge of doing their job to the best of their ability. They cannot, or think they cannot, afford either the luxury of attending National meetings, or of refresher postgraduate courses at some medical center. And probably they are in the greatest need for something of this nature. We are extremely fortunate here in Maine that we have available for these men such courses through the Commonwealth and Bingham Funds. Not only are these courses given at no expense but a stipend of $250.00 a month for living expenses is furnished. While there are no rigid restrictions regarding the allocation of these fellowships, they are primarily intended, and should be utilized, for those who, either through location, or financial circumstances, are not able to arrange for their own graduate education. These courses are given in Boston and cover a wide variety of subjects. A number of fellowships are available each year upon application. The committee on Graduate Education, consisting of Drs. Julius Gottlieb, Lewiston, Norman H. Nickerson, Greenville, and Frederick T. Hill, Waterville, Chairman, will be only too glad to give any information or assistance regarding these fellowships to physicians worthy and desirous of them.

There can seem to be little excuse for a physician not keeping abreast of the Times, if he only realizes the importance of a continued Graduate Education. Reading of contemporary medical literature and attendance at staff, county and State Association meetings furnish a good working basis. This should be supplemented by either attendance at National Society meetings, or refresher courses, or both. To provide for the latter, for those who may not otherwise be able to keep up their Graduate Education, we have these fellowships of the Commonwealth and Bingham Funds. Truly the Future of Medicine in Maine is in our own hands. What are we going to do with it?

*Case History**†‡

A white male, aged 49, an official of an investment council company, was admitted August 18, complaining of weakness, nausea and vomiting.

In the Spring of 1936 the patient was found to have a hypertension; the first blood pressure reading which was known to be above normal was 160 mm. systolic, 100 mm. diastolic, according to the information he received. In spite of medical treatment, the hypertension increased in degree until, a year after its discovery, his blood pressure had become 200 mm. systolic, 130 mm. diastolic. He was nervous and apprehensive about the elevation of blood pressure. In 1937 he was sent to the Mayo Clinic and a splanchnic nerve resection was done in two stages during May and June. Since the operation he had continued to be nervous, had anorexia, constipation, loss of weight and strength. There had been dull pain over the sacrum. Previous to operation his bowels had been regular without cathartics; since operation he had been depending upon salines and a vegetable laxative pill. He had slept poorly because of back pain, which was worse at night. He rose to void urine four or five times during the night. He had been short of breath walking upstairs or up hills since operation. There had been no chest pain on exertion and no subcutaneous edema. He had noticed a slight cough without sputum for several years. He had suffered from frequent occipital headaches and at times had been mildly dizzy. Previous to the operations in May and June his vision had become quite poor, but had improved in the last two months. He was allowed to eat all foods and had done so in small amounts. He had taken one cup of coffee daily and smoked twenty cigarettes a day. His usual weight had been 125 pounds and during the past year there had been a loss of 15 pounds.

After his discharge from the hospital at Rochester he had come to Maine to spend the summer. The last of June he had suddenly developed a right facial paralysis. This was unaccompanied by weakness or paralysis of any of the extremities or speech defect. The facial paralysis cleared up within a week.

He had suffered from scarlet fever in childhood. His tonsils were removed at the age of 9 years. He had had two attacks of influenza. At the age of 47 an operation was performed upon the nasal septum.

His father had died at the age of 65 from apoplexy and his mother at the age of 58 from Bright's disease. There was a family history of hay fever. One brother and one sister were living and well except that the brother suffered from some type of chronic skin disease. One sister had died from intussusception and another from meningitis, which had been a complication of mastoiditis. His wife and two sons were living and well.

When seen July 23, 1937, the blood pressure was 210 mm. systolic, 140 mm. diastolic, the pulse rate was 80, the hemoglobin 70%, height 5 feet 8 inches, and weight 109 pounds. He was obviously thin. The teeth and gums appeared normal. The tonsils had been well removed. There was no enlargement of the thyroid gland. The superficial arteries showed moderate thickening and there was evident lateral excursion of the brachial arteries. There was normal pulsation of the posterior tibial and dorsalis pedis arteries. The neck veins were not engorged. The apex impulse of the heart was located within the mid-clavicular line, the rhythm was regular and there were no murmurs. Examination of the lungs was negative. The spleen, liver and kidneys could not be felt. There was no abdominal tenderness or spasm and no tumor was felt. No subcutaneous edema was present. There were no tremors, but the tendon reflexes were all moderately hyperactive. There was slight remaining weakness of the right facial muscles. Examination of the fundi showed only moderate arterio-venous compression.

The urine showed a specific gravity of

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* Presented at the Clinical Session of the Maine Medical Association, Portland, Maine, October 21, 1937.

† Clinical Presentation by E. H. Drake, M. D., Portland, Maine.

‡ Pathological Presentation by F. F. Ferguson, M. D., Portland, Maine.

1.005. There was no sugar and a moderate trace of albumin. Frequent hyaline casts were seen in the sediment.

A mild sedative and pills of iron sulphate were prescribed. August 13 the patient reported that he had felt considerably better. He was less nervous and was now able to sleep. He was still smoking too much. He frequently smoked before breakfast and had occasionally vomited his breakfast. His appetite had not improved and he had lost two pounds in weight. The blood pressure was 212 mm. systolic, 140 mm. diastolic, and the hemoglobin was 73%. The urine showed a specific gravity of 1.008; there was still a moderate trace of albumin and many casts were found. Shortly after his visit his headache became worse and he started to vomit regardless of meals. Because of the vomiting he was advised to enter the hospital, which he did.

At the time of hospital admission he was quite pale. The blood pressure was 210 mm. systolic, 140 mm. diastolic. There were several hemorrhages in the retina of each eye. The specific gravity of the admission specimen of urine was 1.008; it showed 100 mg. of albumin, hyaline and coarsely granular casts, a few leukocytes and 18-20 RBC. present in the high power field. The hemoglobin was 6.3 gms. (44%) and the red blood count 2,540,000. The MCH was 25, the MCV 100, and the MCHC 25. The red blood cells showed moderate pallor and marked variation in size and shape. The Kahn and Hinton tests were negative. The blood urea nitrogen at 7 A. M. the day after admission was 50 mgs. per 100 c.c.

Fifty per cent. glucose was administered intravenously in 20 c.c. amounts. The headache disappeared and the patient became able to take solid foods and liquids and retain them. Two days after admission the blood pressure reading was 180 mm. systolic, 120 mm. diastolic. There was less obvious nervousness. This improvement was not maintained. The appetite was never really good. There was recurring headache which at times was one-sided, and an old history suggesting migraine was obtained. Because of this new addition to the history, injections of 0.5 c.c. of Gynergen were tried, and it was found that this drug would relieve the headaches promptly.

Nevertheless, there were days when the patient was nauseated and when it was necessary to give intravenous fluids. Not more than 500 c.c. of 10% glucose solution was given at one time intravenously; there were no unpleasant reactions from this treatment. On the ninth hospital day the blood urea nitrogen was found to be 43 mg. per 100 c.c. The patient was seen by a consultant, who advised blood transfusion. The blood of a son was found to cross match perfectly with the patient's, and September 2 a citrate transfusion of 200 c.c. of blood was given. Within half an hour after the transfusion the patient had developed breathlessness so that he was obliged to sit on the edge of the bed. Examination showed moderate numbers of rales in both lower lobes. A hypodermic injection of morphine quieted his apprehension but did not immediately improve the degree of breathlessness. He spent a restless night and was disoriented. The restlessness required a second injection of morphine during the night, following which he showed moderately marked Cheyne-Stokes' breathing and muscular twitching. In the morning he was unconscious with shallow respirations. The blood pressure had fallen to 140 mm. systolic, 80 mm. diastolic. The pulse rate was 82. He continued in a coma with Cheyne-Stokes' breathing, cyanosis, and then more marked pulmonary edema developed and he died early in the morning of September 5th.

Discussion

Unusual causes of hypertension have apparently been excluded. The question then arises as to whether we are dealing with essential hypertension with widespread arteriolar spasm and resulting nephrosclerosis or whether the process was primary in the kidneys. There is a history of childhood scarlet fever, which might have been accompanied by acute nephritis and subsequent chronic kidney disease. A tonsillectomy was performed in childhood. One might infer from this fact that the tonsils had been foci of infection from which kidney disease had originated, but tonsillectomy at the age of nine years is not always performed for the eradication of a focus of infection. As a cause for possible nephritis the history of scarlet fever seems more significant than the tonsil operation. There is a family history of vascular and renal disease. The death of the father of the patient at the age of 65 from apoplexy is perhaps not remarkable. His mother's death from Bright's disease at 58 years seems somewhat more significant. This does not mean that we accept the diagnosis of Bright's disease. Some of us can remember such a diagnosis applied to persons with albuminuria and hypertension, which we should now call essential hypertension rather than primary kidney disease. The marked anemia present in this patient at the time of hospitalization is more suggestive of chronic nephritis than is any of his other physical findings. Because of nitrogen retention and because of the vomiting, which made it impossible at times to secure a sufficient fluid intake without infusions, urine concentration tests were not done. Even if this test had been performed, the results would still leave us in doubt as to whether the process were nephrosclerosis or primary chronic nephritis. Our opinion on this point then must be based in large part upon the history and progress of the case. This patient had obtained life insurance within five years without question. He had received periodic health examinations. It is not probable that the hypertension had been in existence many months before its discovery and its known duration is only a year and a half. If we could be absolutely certain of this fact, it would rule out the diagnosis of chronic nephritis. Scarlet fever then would not have produced serious and permanent kidney damage of a degree sufficient to later bring about his death. This does not mean that microscopic evidence of the effects of an acute nephritis in childhood may not have been in existence at the time of death. The rapidity of the vascular process which killed this patient after a known duration of eighteen months with the retinal changes and the kidney damage justify the diagnosis of malignant hypertension.

No decrease in hypertension and no amelioration of symptoms was derived from the splanchnic nerve resection. Surgeons who have advocated this procedure claim good results in not more than 25 per cent. of cases. The disease seems to have progressed just as it would have had no surgery been attempted. On the other hand, the patient has escaped some of the unpleasant symptoms which may follow such an operation. The tachycardia which sometimes results was not noted. He had been notably weak since the operation and the lack of strength would have prevented his return to work even if he had not elected to spend the summer as a long vacation.

The facial paralysis which occurred in June is of interest. According to our history, the face alone was involved and the lesion was considered to be peripheral. Nevertheless, its occurrence in a patient with this sort of illness makes one suspicious of a vascular lesion in the brain. This is a point on which we must remain in doubt, since permission for examination of the brain after death was not obtained.

The patient's progress during his hospital stay was not encouraging. The summer season was at an end and he should be returning to his home. It was hoped that transfusion might pick him up enough so that he could stand the journey. In retrospect it seems that this procedure was in part responsible for his death, although it is obvious that death within a few weeks was inevitable. The manner in which the transfusion did him harm is not clearly understood. From the symptoms it appears evident that he developed pulmonary edema, probably from acute failure of the left ventricle. There was no transfusion reaction which could be recognized as such. The total amount of blood and citrate was less than 300 c.c. and it was run in slowly. Five hundred c.c. of intravenous fluid had been previously administered without untoward effect. The administration of intravenous blood must have a somewhat different effect than the injection of saline or glucose solutions, but just how this difference could be of sufficient degree to produce sudden failure of the heart and death we cannot say. There had been no previous evidence of heart failure and no symptoms of limitations resulting from poor heart function. In fact, he failed to show the expected cardiac enlargement observed in hypertensive patients.

The clinical diagnosis, then, is malignant hypertension and nephrosclerosis. The autopsy should show predominant renal damage, acute congestion of the lungs, and probably little of significance in the heart itself.

Pathological Report

The findings at autopsy were as follows: Cardiac hypertrophy (weight 450 gms.) and dilatation due to hypertensive and arteriosclerotic heart disease with early arteriosclerotic changes in the walls of the coronary arteries; chronic passive congestion of the lungs, liver, and spleen; arteriolosclerosis of the spleen, kidneys, and adrenals; also a slight amount of arteriolonecrosis of the smaller kidney vessels and slight hypertrophy of the adrenals; healed operative scars (from splanchnic nerve resections).

The chief interest was in the kidneys. The left kidney was much larger than the right, weighing 240 gms., whereas the right weighed only 105 gms., but except for their size their gross appearance was much alike. The capsules stripped with ease, revealing a mottled pale pink surface spotted with dark red areas of hemorrhage. The right kidney showed a small accessory lobule at the upper pole, which was almost separated from the rest of the kidney, with a separate calyx which joined the main pelvis, however.

The microscopic study showed a similar picture in both kidneys. There was marked arteriolosclerosis affecting all the small vessels to varying degrees. In some portions there was scarring and hyalinization of glomeruli with atrophy of the adjacent tubules; in other portions there was colloid degeneration and desquamation of the tubular epithelium, while still other tubules were dilated and filled with inspissated urine. There was also some arteriolonecrosis, particularly of the afferent vessels, with hemorrhage into the surrounding tissue and into the glomerular space.

Most of the damage found in the kidneys seems to have been on the basis of arterial disease, but in the scarred areas it is difficult to state whether the changes may not originally have been due to a chronic nephritis. There was some arteriolonecrosis which is said to be characteristic of essential hypertension. Whatever the cause, however, the kidney damage was too extensive to offer much hope of success from the splanchnic nerve resection. Death was apparently due to cardiac failure.

(Dr. M. C. Winternitz of Yale University was present when this case was presented, and discussed it with particular reference to the difficulty of deciding the relative roles of arterial disease and chronic nephritis in the kidneys. He also emphasized the importance of individual constitution in determining the degree of cardiac hypertrophy which will take place before heart failure occurs. Unfortunately, no notes were made of his discussion, and so no attempt will be made to quote him directly.)

❧

Report of a Case of Herpes Zoster Gangrenosus

By I. Francis Gregory, M. D., Bangor, Maine

Herpes Zoster Gangrenosus may be described as an inflammatory self-limited disease, characterized by the sudden appearance of several elevated milky white vesicles on an inflamed erythematous base, which as the disease progresses, show a marked degree of gangrenous action terminating with considerable scarring or pitting of the skin.

On September 29, one O. H., owner of a gasoline station and wayside stand; a heavy, red-faced, robust, healthy male, 39 years of age, came to my office complaining of a burning sensation over the right supraorbital aspect of the frontal region, and pointing with somewhat alarm to the appearance of five discreet skin eruptions. He claimed he did not notice the latter until that same morning when he was shaving before a mirror. At that time he gave no history of trauma or scratch. He had no subjective symptoms of itching or neuralgic pain or any constitutional symptoms of headache, malaise, chilliness, or nausea.

The vesicular eruption of milky white consistency on an efflorescent base suggested Herpes Zoster. I urged him to return should the condition grow worse. I cautioned him not to attempt to puncture the vesicles, gave him an antiseptic wash, 5% Ammoniated Mercury Ointment and an elixir of bromide for internal use.

On the following day I was called to his home by his sister, who telephoned that he was feeling pretty miserable and that the local lesions on his forehead were spreading. Examination of the patient on the second day of disease showed a gradual increase of the number of vesicles up over the scalp toward the vertex and downward over the bridge of the nose but did not extend beyond the mid-line. The patient complained of malaise, lameness in the joints, chilliness, nausea without vomiting, and yet he carried no temperature. On this date, the second day, I began periodic local applications of hot saline packs.

It is reported by many writers that the outbreak of the vesicles is synchronous with neuralgic pain. It was not true in this case. The eruption made its appearance suddenly, consisting, as I have stated before, of five slightly elevated milky white vesicles or blebs, varying in size, situated in the center of a small hyperemic or macular efflorescent base; the eruption made its appearance to the right of the mid-line over the area supplied by the supraorbital nerve, which springs from the first branch of the trigeminous, with only one subjective symptom that of a slight burning sensation. The vesicles showed no tendency to spontaneous rupture. It was some five days before all newer patches or vesicles made their full-blown appearance: this might be termed the first stage of the disease.

On the third day of this stage, the patient ran a temperature of 102, pulse (80-90), being low in proportion to the temperature. He complained of chilliness and a marked degree of malaise, loss of appetite, nausea with vomiting. There was no evidence of adenopathy, probably because of the distribution of the lesions. The eruption was for the most part unilateral with a very few small scattered lesions appearing on the opposite side, not contiguous but some distance from the mid-line. Some observers have noticed bilateral distribution; others have observed in addition to the characteristic unilateral regional eruption a general distribution over the body surface similar to varicella-like or chicken pox lesions. I was impressed from the character of the lesions and later from the marked pitting of the skin of a pox relationship between Herpes Zoster and Varicella; in fact, to see the patient today, one would say he had had smallpox, so marked is the scarring and pitting, the latter disfiguration being common in Zoster Frontalis.

The location of the localized lesions was over the right supraorbital region extending back over the scalp to the vertex and the mid-parietal region laterally. Various regional names are given to the malady because of its location. This case might be included under Zoster Frontalis, Zoster Ophthalmicus. This case was alarming to the attendant because of its extension over the right eye and nose. Serious and disastrous consequences were looked for: involvement of the eye, meningitis and death. Apparently the only mean residuum is the unsightly pitting which would have been calamitous in a female.

Herpes Zoster may occur at all ages, and is more common in the male. It is seen most frequently between the ages of ten and forty. Seasonally, it is seen more frequently during spring, autumn and winter. Many causes are given for the production of the disease: exposure to cold and wet, atmospheric changes, peripheral nerve irritation, administration of arsenic and infection. I am impressed with the theory of a specific infectious organism.

The pathology of Herpes Zoster involves the ganglionic nerve fibres. As a general rule the ganglia show inflammatory signs; the nerve fibres are likewise inflamed and enlarged. The skin lesion represents the terminal phenomenon of a descending involvement of the end plates of the involved nerve and its branches. The limpid contents of the vesicles become lactescent or puriform in character, consisting of some pus cells and epithelial cells. No organisms were determined from the seropurulent discharge. Later, deeper destruction of the corium took place with the inevitable scarring.

The tough, milky white vesicles grouped within a limited inflamed area, unilateral, spreading along the course of a peripheral nerve are characteristic of Herpes Zoster. The inflamed area at first was confusing. Had the contents of the vesicles been more transparent, one would think of erysipelas from the specific inflammation of the skin of the face, which in this instance was characterized by a shining redness with edema and heat. The patient had the prodromal symptoms accompanying an erysipelas, such as malaise, chilliness, nausea and vomiting. However, from the third to the fifth day, it was evident that then, at the height of the lesions, there would not be an extension beyond the mid-line. The line of demarcation was striking, for the lesions spread upward and downward but never overstepped except for a few isolated vesicles which appeared later some distance from the mid-line.

When first seen in the office, when there were but a few patches, the condition might be confused with a vesicular eczema, but there was no itching; only a burning sensation. Rhus or ivy poisoning may be thought of during the initial stage. Many varieties of character of the lesion are met with varying from the simple irritation through the intermediate degrees of vesiculation, erysipelatous and edematous swelling to the rare instances of gangrenous action with ulceration and destruction. However, the cutaneous lesions in rhus poisoning do not follow the course of a nerve and is more generalized, never strikingly demarcated by the mid-line.

The prognosis of Herpes Zoster in all its forms is favorable. The symptoms usually disappear within three to four weeks: this case lasting twenty-one days. However, in old people, in those whose health has been undermined, poorly nourished, the prognosis should be guarded for in the latter type, chronic ulcerative cases may terminate fatally through exhaustion or a septic condition. In this case, when the right eye and nose were involved, and the generalized edema closed not only the involved right eye but the left as well; with the changing of the characteristic milky white vesicles to that of black stippled greenish areas, the outlook was questionable and dubious. Involvement of the right eye was feared and so great was the inflammation and edema about the nose, a migrating infection to the meninges was looked for.

It was fortunate that the gangrenous complication, the second stage of the disease with its resultant pitting and scarring of the involved region, the terminating or third stage, occurred in a male and in one who was not fastidious about his facial appearance. Had this condition occurred in a beautiful young woman the result would have been disastrous. There has been no residual neuralgia, anesthesia, paralysis or atrophy.

Although I realize that Sulphanilimide has been hailed as a panacea for many ills, I was profoundly impressed by its use when on the third day of this disease with the fever running somewhat high, I attempted its use, playing with the idea that after all I might be dealing with an atypical erysipelas infection of streptococcic origin. The patient was given ten grains of Sulphanilimide every four hours for five doses on the third day. The following morning the temperature was normal and the patient feeling much better generally. I discontinued the drug on the morning of the fourth day only to observe that again on the fifth day the patient had a temperature of 102 and generally had a relapse of symptoms. I repeated my administration of Sulphanilimide and continued for ten days, diminishing the dose as time went on, watching for any suggestion of a leukopenia or hemolysis by doing repeated R. B. C., W. B. C. and blood smears. On the morning of the fifth day 0.6 grams of Neo-Arsphenamine was given when a blood report returned by the State revealed, Kahn—one plus.

The patient was attended by a trained nurse for twenty-four hours who applied hot saline packs to the scalp (the hair being shaved off), eyes and face. Both eyes cleansed with boric acid solution every three hours. The local burning sensation and the generalized irritability of the patient which on the fifth day bordered on a mild irrational state was controlled by morphia. Liquid diet was the regime for one week. Ultra-violet therapy was begun on the tenth morning of disease and continued until all crusts and the thick exudative masses had lifted and could be washed away with Hydrogen Peroxide solution.

Many have used the coal tar products for constitutional treatment. A combination of codeine, acetyl salicylic with caffein was tried on the third day but had no effect. I think if I were to see another case, I would discontinue the hot packs in the later stages of the disease and substitute with a dusting powder. The latter would have been more comfortable for the patient and I doubt if any benefit was obtained from the hot packs after the deep corium layer had been destroyed. Caution had to be used in the selection of drugs for local application in this case for such a wet dressing as carbolized alcohol, etc., would be hazardous in and about the region of the eye. I once saw in my own practice a severe case of conjunctivitis from the use of chrysarobin ointment used in a ringworm infection of the lower lid.

Herpes Zoster is not rare in itself. However, some of its manifestations such as this case of gangrenosus is not common. The disease itself is limited and the prognosis good but when the lesions are extensive on the face about the eye and nose the prognosis should be guarded. Luckily this patient was of the robust healthy type with much reserve to call upon. I feel I have every reason to assume that Sulphanilimide played an important part. Certainly its use and non-use was striking. I regret the scarring and pitting for I realize how calamitous this would be to a young woman: it would probably mean the origin of a depressive neurosis for many years.

* * *

*Some Modern Trends in the Therapy of Pneumonia**†

In the matter of general care, we find that the importance of comfort, quiet, fresh air and the various other factors are regarded as highly today as they were in previous decades.

Emphasis is being laid on the advisability of *not disturbing pneumonia patients more than is necessary,* and Linnell makes the further interesting suggestion that we let the patient, to a large extent, decide upon the posture that is most conducive to his comfort.

In every department of medicine purgation is being employed *less* than in past years, and it certainly appears reasonable that in pneumonia the avoidance of the disturbance and exhaustion incident to purgation would seem advisable.

Glucose administered intravenously as a therapeutic measure has fallen largely into disuse.

Serum holds the first place in interest so far as specific therapy is concerned. The recent developments in the process of typing

* Excerpts from Therapy by O. W. Bethea, *International Med. Digest*, March, 1936.

† Read at Medical Review Conference, Belgrade, Maine, June, 1937.

the organisms through the use of the rabbit pneumococcus anti-serum by utilizing the Neufeld reaction has made possible in a few hours *typing* that formerly required two or more days.

There are several factors militating against the applicability of specific serum therapy.

Finland expresses the majority opinion when he states that the efficacy of serum treatment depends strictly on type specificity. Leopold advocates the use of serum, but feels that it is of value *only* if employed early.

1. The consensus of opinion is that in type I pneumonia serum may be of marked value; in type II, of possible value, but less specific, while for other types the value of serum is still unproved, though it seems to be promising for several of the other groups.

2. To be of value, serum must be used early, some say not *later* than the third day, and *few* recommend serum after the fourth day.

3. To be of value the serum must be type specific, that is, type I serum for type I pneumonia.

4. To be of appreciable value it is generally conceded that the serum must be given in *large* doses. Two hundred thousand units as recommended by Cecil for the first day's treatment for type I pneumonia would cost about $150.00.

Oxygen is commanding much interest as a therapeutic agent for many conditions, but especially in the pneumonias. There is no doubt that the use of this agent recently has been put upon a more efficient basis.

One thing seems certain, and that is, that once a pneumonia patient has been placed in the oxygen tent he should remain there until convalescence is established definitely. Collins gives as indications, dyspnea, cyanosis, rise in pulse and respiratory rate and delirium.

Artificial pneumothorax has many advocates. Leopold in an excellent discussion gives primary credit for this procedure to Rood of the U. S. Army, who first made use of it in 1918. He states that it favorably influences pain, temperature, cyanosis, cough and other symptoms and is convinced of its value.

Vaccines still have many advocates both in prophylaxis and treatment. Lintz feels that their use is not justified. Cole considers that their value in prophylaxis is still unproved; Cecil thinks that they probably will have a field of usefulness. The leading advocate of vaccine as a *therapeutic* measure in pneumonia is Lambert, and his standing in clinical medicine is such that his opinion naturally commands much respect.

Various chemicals have been advocated from time to time. Quinine today has only a few advocates but among these we find men of such caliber as the Solis-Cohens. Ethyl hydrocupreine (optochin) has been used rather extensively in Europe, but infrequently here. Cole acknowledges that the results in laboratory animals are intriguing, but feels that its practical application to man is yet undeveloped. Carr states that after a thorough trial he discontinued its use.

Many drugs are used in symptomatic treatment. Among these *morphine* is of special interest.

Digitalis in pneumonia is used much less today than it was a decade ago. Collins states the present consensus of opinion, when he says that digitalis is to be used in the presence of *fibrillation*, *flutter* and *failing compensation.*

An interesting question has been answered largely by the excellent work of Weinstein, who has done much to prove that pre-existing syphilis is *not* the common cause of delayed resolution and that the routine employment, therefore, of antisyphilitic therapy in these cases is not justifiable.

We find a few voices raised in favor of treating the *patient* and not the disease, just as is done in typhoid fever. I have felt that specific measures under favorable conditions are available to so small a percentage of cases, that it is rather to be regretted that so little attention has been paid in literature to the care of that great majority of patients who must be treated *without* the possible benefit of such therapy. I have become more and more convinced that infinite attention to the details of general care and a policy of the employment of the least possible medication or other interference is at least worthy of further consideration.

The President's Page

TO THE MEMBERS OF THE MAINE MEDICAL ASSOCIATION:

In the November number of the JOURNAL I made some general statements in regard to the neonatal and maternal mortality in this country as compared to other countries, and in the State of Maine, as compared to other States in the union. I have received several communications asking me to be more specific in my statements and this I am glad to do.

The neonatal mortality rate is low in the United States as compared to foreign countries. Of reports from twenty-nine countries, twenty-three had higher rates and only six had lower rates than the United States.

The neonatal death rate for this country per one thousand live births is thirty-two, while Australia had twenty-eight, Denmark twenty-nine, Irish Free State twenty-seven, Netherlands twenty-two, Switzerland twenty-nine and Uruguay thirty (1934).

The neonatal mortality in Maine is high as compared with other States. Our rate is 38.5 per one thousand live births and this is only exceeded by Arkansas, Colorado, Georgia, Nevada, New Mexico, South Carolina and Virginia.

The maternal death rate in the United States is very high as compared to foreign countries and is 63.3 per ten thousand live births. This rate is only exceeded by Scotland with 77.7 per ten thousand live births.

Quoting from Bureau Publication No. 229 of the U. S. Department of Labor: "The methods of assignment in use in Australia, Netherlands, New Zealand and Scotland are similar to that of the United States, and the official maternal mortality rates are directly comparable within a small margin of error. Under the method of Denmark a larger number of deaths would be assigned to the puerperal state and the rate for the United States would be significantly higher than it is now. Under the methods of other countries, such as Canada, Chile, England, Wales, France, Italy, Norway and Sweden, a smaller number of deaths would be assigned to the puerperal state and the rates for the United States would consequently be somewhat lower."

"The difference in methods of assignment is insufficient to explain the high maternal mortality rate of the United States as compared with foreign countries."

In comparing Maine with other States our maternal mortality rate is about average for the whole country. Our rate is 57. to ten thousand live births while twenty-four States have higher rates and twenty-three lower. As a State, therefore, we have a fair standing.

It is agreed by all authorities, however, that our maternal mortality, as a nation, is much too high and can be materially lowered if certain definite reforms are instituted.

It is hoped that the Maternal Welfare Committee of the Maine Medical Association will institute reforms that will definitely lower the maternal mortality in this State.

RALPH W. WAKEFIELD, M. D.

R.W.W./c

Editorials

Principles and Proposals of the Committee of Physicians

Very recently the lay press had a syndicated and splash article, decidedly spotlighted for the laity, to the effect that four hundred and thirty of the nation's most distinguished physicians had thrown down the gauntlet to the officers of organized medicine and had gone on record that it must be the duty of the medical profession to coöperate with the Government in measures for the conservation and improvement of the public health and that their profession imposes on them a social responsibility that they must shoulder. In doing this, so infers the article, these doctors have gone on record as opposing the powerful American Medical Association which has repeatedly opposed every effort to "socialize" the practice of medicine, on the plea that it would result in doctors becoming public servants, subject to orders from political sources and being inadequately compensated for their services. Evidently it was felt by this exceedingly small minority, for that inference is drawn in the article, that this committee "has something on the ball" unfortunately lacking in the rank and file of the profession. The plan of the eminent physicians, reputedly endorsed by the New York State Medical Association, would gain some of the objectives of *socialized medicine,* just what these consist of was not mentioned, without State control of the medical profession. Again that extremely vague but useful term, adequate care, is employed, suggesting to the uninformed that the profession, as a whole, has fallen down on its job and that help is being denied the unfortunate.

Whether the committee intended to create such an impression is immaterial. The fact is beyond rebuttal that those interested to that effect are conveying the idea that the officers and members of The American Medical Association are not only obstructionists but that they regard the practice of medicine as a vested right, to be fought for and retained with nothing but selfish interests in view "while *millions* lie ill without adequate care or DIE because it costs too much to have a doctor." It requires quite some stretch of one's imagination to believe that the expense of this nation-wide article was assumed entirely by this committee.

Under our present form of Government, distasteful, of course, to some, it would seem that the problem of furnishing adequate medical care to the needy is a problem for the proper authorities in each State and the local profession to study and then apply whatever remedy that circumstances and need call for. It is to be sincerely hoped that not only the American Medical Association, but physicians individually and collectively, will continue to oppose in every legitimate way any attempt to make the profession "public servants and subject to orders from political sources." As emphasized in an authorized statement from the Board of Trustees, *Journal of the A. M. A.,* November 27, 1937, the American Medical Association reaffirms its willingness on receipt of direct request to confer with, aid in any possible manner, any governmental or other qualified agency. This offer stands, not only for the American Medical Association, but for any of its component State associations or County Societies. Thus far no such call has come to the office of the American Medical Association.

Postgraduate Institute on Pneumonia

Appearing under the foregoing title as a special article in the *Journal of the A. M. A.,* for December 18, 1937, is one of the most valuable and helpful discussions concerning this disease. Physicians have come to regard the imperative necessity for prompt diagnosis and treatment in appendicitis, ectopic pregnancy and other well-known abdominal catastrophies, and it can safely be said that pneumonia, to be treated intelligently and with a lowering of mortality, must be placed in the same category. One of the clearest talks on this subject that we ever have heard was given by Peter Irving of New York at the recent meeting of State Secretaries and Editors in Chicago in November. Fortunately, this paper will be presented in a forthcoming issue of the *Journal of the American Medical Association.*

There are twenty-three typing stations in the State of Maine. We are informed by Dr. George H. Coombs of the Maine State Bureau of Health, "We disregard night hours, holidays and Sundays, when serum is needed, and get it there promptly." In view of the extreme necessity for prompt diagnosis, the importance of establishing, as soon as humanly possible, the type of pneumococcus, in order that the serum in types for which it is available can be used promptly, and hours count, not days, the articles referred to should be read by every practitioner. Free serum is supplied by the State on recommendation of the attending physician and if serum is not available for a patient able to assume its cost, it will be furnished promptly by the typing station or the Department of Health at Augusta.

As stated by Cole, in his discussion of the serum treatment of pneumonia, "It seems rather unimportant and rather misleading, therefore, to think of pneumonia as a fixed condition. That is why it is so difficult to determine the exact therapeutic value of any kind of treatment." Unquestionably this is a fact, but from evidence presented by careful clinicians it does seem as if serum for type I infections offered much in the way of lowering the mortality. It is well, however, to emphasize that all observers lay stress on the fact that serum treatment *must* be instituted *early* and the required amount used.

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County News and Notes

Androscoggin

The regular meeting of the Androscoggin County Medical Society was held November 18, 1937.

Meeting called to order by the President at 8.48 P. M. Held at the DeWitt Hotel preceded by a dinner.

Minutes of the last meeting were approved as read.

A letter from Dr. Leland of the Bureau of Economics was read pertaining to fee schedules. Notification having been sent to the effect that we had none available, Dr. Gauvreau appointed a committee of the following to draw up a report on this matter. Those appointed comprised: Drs. H. W. Garcelon, L. O. Roy, M. S. F. Greene, W. L. Haskell, W. E. Webber.

A letter from Dr. F. B. Ames, Chairman of the State Cancer Committee, was read, requesting that county societies plan to hold at least one full program on the subject of cancer during the year. At the suggestion of the secretary the suggestion is to be placed in the hands of the incoming administration for their consideration.

Two applications for membership were on the table for disposal. The one of Dr. W. E. Viles was passed by vote of the members present. The other, of Dr. C. Nobili, which did not fulfill the requirements of a residential practice within the jurisdiction of this county society, was rejected, as per Section I, Article 1, of our By-Laws.

There were no reports from any of the Standing or Special Committees.

Dr. R. L. Mitchell, of the Department of Health and Welfare, was present by invitation and gave some sidelights concerning the extension courses on the subjects of obstetrics and pediatrics which are available to the members of this State this coming year.

Concluding the regular business of the society, Dr. Gauvreau turned the meeting over to our invited Toastmaster, Dr. J. G. Towne of Waterville, the meeting being designed to honor the members of our society who have been in practice for 35 years or more. The honored members were the following: Drs. A. W. Plummer, W. L. Haskell, W. E. Webber, W. J. Renwick, C. C. Peaslee, F. S. Wakefield, O. E. Hanscom, G. H. Hutchins, G. H. Rand, E. F. Pierce, J. J. Pelletier and S. L. Andrews.

Members of the Maine State Board of Registration in Medicine who were present were Dr. J. G. Towne, Dr. R. D. Simons and Dr. Adam P. Leighton, the Chairman, who is also the Chairman of the Committee on Education and Hospitals in the State Association. Following a few remarks by Dr. Simons, the speaker for the occasion, Dr. Adam P. Leighton, was introduced by the Toastmaster, who in the course of his talk outlined the duties and activities of the Registration Board in this State, and its aim to maintain the accepted standards of medical requirement as compared with other states. Many valuable suggestions were made by the speaker for future reference, including our relationship in the development of State Medicine, status of men migrating from the European Countries into our states, and particularly the importance of individual county medical opinions as representing the practitioner in our future state activities. His talk was well received, delivered, concise, and interesting in all its phases, as to make it one of our outstanding presentations of the year.

Following the speaker, various members of the 35-year group honored at this meeting were called upon, with appropriate anecdotes, to say a few words which were cordially received by the members. Dr. Ralph W. Wakefield, President of the

Photo by Courtesy of Lewiston Sun-Journal

Back Row: A. W. Plummer, M. D. W. L. Haskell, M. D. G. H. Rand, M. D. S. L. Andrews, M. D. W. J. Renwick, M. D. E. F. Pierce, M. D.
Sitting: J. J. Pelletier, M. D. C. C. Peaslee, M. D. G. H. Hutchins, M. D. W. E. Webber, M. D. O. E. Hanscom, M. D.

The above members of the Androscoggin County Medical Society who have been in practice thirty-five or more years, were honored at a meeting held in Lewiston, November 18, 1937

Association, was introduced, and extended a very cordial appreciation to the men honored at this meeting, and remarked that the idea was one to be promulgated by him as he appeared before the other societies of the state, during his tenure.

Following the remarks made by members honored by this particular meeting, one of the most interesting held by this county society, it was brought to a close by the President at 10.46 P. M.

Respectfully submitted,

A. E. Peters, M. D., *Secretary.*

The regular meeting of the Androscoggin County Medical Society was held December 16, 1937.

The meeting was held at the Auburn Y. M. C. A. and opened by the president at 9.45 P. M.

Minutes of the last meeting were approved as read.

There was no correspondence on the table, and no applications for membership.

There was no report from the committee on Fee Schedule appointed at the last meeting. This was carried over to be brought up at the next meeting.

On the receipt of some new Vital Statistics forms by the president, a committee comprising Drs. L. A. Sweatt, H. Sprince, and P. Chevalier was nominated to bring in a report as to any recommendations on the same.

There was also some new forms relative to the standing orders used by the nurses of the local Red Cross Chapter brought in to be passed upon by the society. A committee comprising Drs. W. L. Haskell, R. Beliveau, and W. V. Cox was appointed to bring in a report on this at the next regular meeting.

Following information given by Dr. L. A. Sweatt that an osteopath was to be appointed as Medical Examiner in Lisbon, a motion was made and carried that the secretary be instructed to communicate with the Governor carrying the sentiments of the society as against such procedure particularly where a medical man in good standing is available. A previous letter received from the Governor this year on the same subject was recalled.

At the same time, Dr. Wallace E. Webber mentioned the situation in Lewiston where an osteopath fills the city physician's office. Following a discussion, a motion was made and carried that the secretary be instructed to send a letter of protest to the Lewiston Council from the society with a recommendation that the salary of this office be raised to a respectable level that would warrant consideration by a medical practitioner.

Following the conclusion of the business meeting, the speaker of the evening, Atty. Herbert E. Locke, State Association Counsel, was introduced by the president. Mr. Locke gave an interesting discussion on various phases of medico-legal procedure in this State during which he reminded the members of the advisability of all being associated with a single company.

Invited guests present were Drs. W. E. Kershner of Bath and Robert W. Belknap of Damariscotta, who being associated with medico-legal state committees in the past rendered additional interesting remarks on the subject. The society was commended by Dr. Belknap in holding such a meeting at least once a year to maintain the interest and importance of its business functions before its members.

The attendance was well maintained with over 30 members present. It was voted at this time that the future regular meetings be held at the Auburn Y. M. C. A. in view of the advantages of the location.

Meeting was adjourned at 11.00 P. M.

Respectfully submitted,

A. E. Peters, M. D., *Secretary.*

Aroostook

Resolutions

Dr. Melvin J. Brown of Mars Hill, Maine, was born on February 26, 1852, in the town of Blaine, Maine, the son of Samuel and Catherine Arnold Brown, the fifth child in a family of fifteen and the first to be born in the "Log House" in Blaine. He died June 16, 1937, at his Mars Hill home.

On June 6, 1893, he married Ida M. Wilson of Blaine, who survives him.

Dr. Brown entered Dartmouth Medical College in 1893. The hospital facilities at Dartmouth at that time being very limited, he decided in his second year to enter Baltimore Medical College, now the University of Maryland, where he graduated in 1896.

Dr. Brown had a long and successful career in the practise of medicine, the first twenty years in New Bedford, Mass., and the remaining years in Mars Hill.

He was a man of the highest type of character, an able physician, always interested in the welfare of his community and its citizens.

His passing was a distinct loss, not only to his locality but to Aroostook County, and its medical society, of which he was an active, and always *present* member.

Dr. Brown's greatest interest outside of his profession was the Masonic Lodge, of which he has been a member for 44 years.

To his bereaved family the Aroostook County and State Medical Societies extend their sincerest sympathy.

Voted that a copy of these resolutions be placed on the records of the County and State Society and a copy be sent to Mrs. Brown.

For the Committee,

F. W. Mitchell.

Cumberland

George W. Holmes, M. D., Clinical Professor of Roentgenology, Harvard Medical School, discussed *Pulmonary Hemorrhage with Special Reference to Differential Diagnosis by X-ray* at the dinner meeting of the Cumberland County Medical Society in the Eastland Hotel, Monday, November 29th. This meeting was preceded by a clinic held at the Maine General Hospital.

Harold V. Bickmore, *Secretary.*

Henry M. Swift, M. D., was elected President of the Cumberland County Medical Society at the annual dinner meeting in the Eastland Hotel, Friday, December 10th.

Other officers elected were:

Vice-President, E. G. A. Stetson, M. D., Brunswick.

Secretary-Treasurer, Harold V. Bickmore, M. D., Portland.

Councillors, Walter E. Tobie, Charles H. Hunt and Harry E. Emery.

Committee on Legislation, Charles B. Sylvester.

Committee on Outside Relations, S. Judd Beach, Donald H. Daniels and Samuel Sawyer.

Delegates to the 1938 State Association meeting at Bar Harbor, Elton R. Blaisdell, Langdon T. Thaxter, Ralph A. Getchell, Luther A. Brown, William D. Anderson, T. M. Stevens, H. W. Hanson, Jr., and J. C. Oram.

E. H. Risley of Waterville, the speaker of the evening, read a paper on *Cancer of the Rectum and the Aftercare of Colostomies*. On motion of W. D. Anderson, M. D., it was voted to publish Dr. Risley's paper in the MAINE MEDICAL JOURNAL.

A clinic held at the Maine General Hospital during the afternoon was participated in by Drs. Roland B. Moore, Charles H. Gordon, Isaac M. Webber, Elton R. Blaisdell, George A. Tibbetts, E. H. Drake and H. L. Curtis.

HAROLD V. BICKMORE, *Secretary*.

Portland Medical Club

The annual banquet meeting of the Portland Medical Club was held at the Lafayette Hotel on Tuesday, December 7th, at 7 P. M. 64 members and 4 guests were present.

Resolutions on the death of Dr. Albert E. Awde were adopted by the Club.

The following officers were elected for the ensuing year:

President, Luther Brown, M. D.

Vice-President, Eugene O'Donnell, M. D.

Second Vice-President, Alvin Morrison, M. D.

Secretary-Treasurer, Alice Whittier, M. D.

Board of Censors, Thomas A. Foster, M. D., Eugene Drake, M. D., C. B. Sylvester, M. D.

The oration was delivered by A. D. Foster, M. D. His subject was "Some Experiences in the Work of the Public Health Service." He told of his medical service and experiences in Italy, China, the Philippines and the United States.

ALICE WHITTIER, *Secretary*.

Kennebec

The annual meeting of the Kennebec County Medical Association was held at the Augusta State Hospital, Thursday, December 16, 1937.

Clinical Program: 5.00 P. M.

Presentation of cases by members of the staff.

Dinner: 6.30 P. M.

Followed by a business meeting and scientific session. Minutes of the last meeting were read and approved.

Dr. Harry Warshawsky and Dr. Matthew T. Moorehead of Togus were admitted to membership.

The reports of the secretary and treasurer were read and accepted.

The following members were appointed by the Chair to nominate the officers for the ensuing year: Dr. John O. Piper, Waterville; Dr. Maurice A. Priest, Augusta; Dr. Chalmers G. Farrell, Gardiner.

They reported as follows:

President: Samuel H. Kagan, M. D., Augusta.

Vice-President: Leon D. Herring, M. D., Winthrop.

Secretary-Treasurer: Frederick R. Carter, M. D., Augusta.

Councilor for Three Years: John P. Goodrich, M. D., Waterville.

Delegate to the Maine Medical Association: Howard F. Hill, M. D., Waterville.

Alternate: Armand Guite, M. D., Waterville.

M. T. Shelton, M. D., of Augusta, to replace Leon D. Herring, M. D., of Winthrop, as a member of the Council of the County Society as Dr. Herring was elected to the Vice-Presidency.

It was moved and seconded that the by-laws be suspended and the Secretary cast one vote for the officers for the ensuing year which was done.

The address of the evening was presented by F. C. Tyson, M. D., Superintendent of the Augusta State Hospital, "Psychogenic Factors in the Causation of Mental Disorders." This was very interesting and brought out a great deal of valuable discussion.

There were 35 members and guests present.

FREDERICK R. CARTER, *Secretary*.

Penobscot

The regular monthly meeting of the Penobscot County Medical Association was held Tuesday, December 21, 1937.

Afternoon session at the Eastern Maine General Hospital. A clinic was held under the direction of Dr. Allan M. Butler, of the Children's Hospital, Boston, Mass.

In the evening, following a dinner at the Bangor House, the regular monthly business meeting was held. The following resolutions were adopted on the death of Dr. Charles S. Bryant of Millinocket:

WHEREAS, Divine Providence has summoned from our membership, Dr. Charles S. Bryant,

Be It Resolved, That in the passing of Dr. Charles S. Bryant, the Penobscot County Medical Association has lost a valued member; the medical profession an outstanding physician and surgeon; his patients, not only an able medical counselor but also a true friend; the community in which he lived an esteemed citizen and a cultured gentleman.

Be It Further Resolved, That a copy of these resolutions be spread upon the records of the Association and a copy forwarded to each of the following: Miss Annie Bryant, Mr. Fred Bryant, Mr. and Mrs. Frank C. Bowler.

(Signed) EUGENE B. SANGER, M. D.,
ERNEST T. YOUNG, M. D.,
Committee on Resolutions.

Dr. John M. Hoyt, Assistant Physician at the Bangor State Hospital, was elected to membership.

The speaker of the evening was Dr. Allan M. Butler, of Boston, Mass. His subject was: "The

Principles and Proposals for Improving Medical Care." As a member of the original Committee of Physicians, Doctor Butler is specially well qualified to deal with this very important subject. His presentation was carefully and fairly made and was very thoughtfully received by the members of the Association.

FORREST B. AMES, M. D.,
Secretary.

Sagadahoc

The regular meeting of the Sagadahoc County Medical Society for November was held at the Hotel Sedgwick on Tuesday, November 16th, at 6.30 P. M., President Pratt of Richmond presiding. Those present were Drs. Snipe, Joseph I. Smith, Jacob Smith, Joss, Fuller, Day, Bailey and Winchenbach.

Guests were Drs. Esmond of Richmond, Belknap of Damariscotta, Hebert of Lewiston and Julius Gottlieb of Lewiston, the guest speaker.

A very fine dinner was enjoyed and the business meeting followed.

A request from the A. M. A. for a county fee schedule brought forth considerable discussion and resulted in a Committee being appointed to present a schedule for adoption by the society at the January meeting.

The officers elected were: President, E. F. Pratt; Vice-President, H. D. Grant; Secretary and Treasurer, F. A. Winchenbach; Delegate, A. F. Williams; Board of Censors, Joseph I. Smith, Merrill Joss, B. A. Bailey.

Dr. Julius Gottlieb of Lewiston presented a very interesting and instructive program based on Laboratory Aids to Diagnosis.

FRANCIS A. WINCHENBACH, M. D.,
Secretary.

New Members

Androscoggin: Wallace E. Viles, M. D., Turner.

Cumberland: John V. Ward, M. D., Portland; Louis A. Asali, M. D., Portland; Benjamin Zolov, M. D., Portland; Alvin E. Ottum, M. D., Portland.

Kennebec: Harry Warshawsky, M. D., Togus; Matthew T. Moorehead, M. D., Togus.

Penobscot: John Mitchell Hoyt, M. D., Bangor.

Removal Notices

J. Foster Wellington, M. D., has moved to 655 Congress Street, Portland. Former address 142 High Street.

Coming Meetings

Cumberland

February: Date and program to be announced.

Waldo

WALDO COUNTY MEDICAL SOCIETY

The Waldo County Medical Society will meet at the Windsor Hotel, Belfast, Wednesday evening, January 19, 1938, with dinner at 6.30.

The annual election of officers will be held at this meeting.

Edward H. Risley, M. D., of Waterville will address the Society on *Cancer of the Rectum and the Aftercare of Colostomies.*

RAYMOND L. TORREY, M. D., *Secretary*, Searsport

Necrologies

Doctor John Wilder Bowers

Doctor Bowers died in the Maine General Hospital on the morning of Tuesday, December seven, having undergone his twenty-seventh surgical operation a few days earlier.

He was born in Saco, Maine, on July 16, 1861, the son of Roscoe L. and Sarah Berry Bowers, and received his preliminary education in the schools of his native city, graduating from the Saco High School in 1879. He prepared for the general practice of medicine at the College of Physicians and Surgeons in Baltimore, and, following graduation in 1882, went to the middle west to engage in general practice for several years. After a brief residence in Chicago, Dr. Bowers took up practice in

Minnesota, and, while thus engaged, in the year 1886, he pursued special studies in the Medical School of the University of Minnesota. Two years later he went to Germany to study Ophthalmology at the Universities of Jena and Berlin. After two years abroad, Dr. Bowers returned to the United States and located in Portland in 1891, since which year he has specialized in diseases of the eye up to the date of his retirement about three years ago.

Dr. Bowers was an honorary member of the Maine Medical Association, the Portland Fraternity Club and The Purpoodock Club at Cape Elizabeth.

On November 28, 1894, he married Miss Alice Maud Allen of Portland, who died three years ago. He is survived by a sister, Mrs. Robert W. Hall, wife of the professor of biology at Lehigh University.

Those who were close to Dr. Bowers knew a man of rare personal charm. In his several European trips, one of which included a trip around the world, he formed the acquaintance of many distinguished persons in different walks of life. Among them must be mentioned Ernst Haeckel, the German Darwin, with whom he associated intimately for months while at Jena. To those of us less fortunate in opportunity to travel than he, the doctor delighted to recount his experiences. This he could do in inimitable fashion, for he possessed the gift of narration that captivated and thrilled his listeners.

Dr. Bowers loved life and his fellow-men. His patients adored him, not alone for his professional skill but, also, for the very real personal interest that he took in their problems.

With his passing, the profession has lost a skilled oculist, and society, a courteous, genial, lovable, thoroughbred gentleman, a most companionable man.

E. W. Gehring.

Doctor Earle Pope Gregory

Doctor Gregory died at his home in Fryeburg, Maine, November 20, 1937, of coronary thrombosis following a nine-day illness.

He was born in Mt. Upton, New York, September 29, 1877. He was graduated from Oneonta State College in 1900 as professor of mathematics and taught for several years before entering the University of Michigan. In 1909 he was graduated from the University of Michigan Medical School, after which he took a special course in health work in Albany, New York, and was appointed health commissioner of three counties in that State.

He received a civil service commission from the United States Government and was stationed at Culebra Hospital, Panama, during the building of the Panama Canal. This was followed by special courses in neurology in Wisconsin and dermatology at the Post-Graduate Hospital, New York. Doctor Gregory took up general practice at Arkport, New York, in 1912, moving to Fryeburg in 1920, where he had built up a large practice. He was appointed medical examiner under Governors Percival P. Baxter, Ralph O. Brewster, William Tudor Gardiner and Lewis O. Barrows.

He was a fellow of the American Medical Association, and a member of the Cumberland County Medical Society.

Doctor Herman Wesley Small

Herman Wesley Small was born in Deer Isle, Maine, March 31, 1865. He attended the schools of that town and Kent's Hill Seminary. He then entered the University of Vermont, from which he graduated in 1890. He took post-graduate courses in Post-Graduate College and Hospital, New York, and Harvard Medical School.

Doctor Small, a member of the Cumberland County Medical Society, died October 8, 1937.

Stephen Earle Vosburgh, M. D.

Dr. Stephen Earle Vosburgh, Superintendent of the Pownal State School, died at his residence at Pownal, Maine, December 24, 1937, at the age of 56. He had been ill for about four months. Dr. Vosburgh was born in Greenfield, Mass., January 29, 1881, the son of Stephen and Ella Augusta (Carter) Vosburgh. He was educated in Greenfield schools and Jefferson Medical College, graduating from the latter institution in 1905. After receiving his degree he served as a physician in King's Park State Hospital, New York, first assistant physician in Boston State Hospital, executive assistant in the Boston Psychopathic Hospital, and then came to Maine in 1912 as assistant superintendent of the Augusta State Hospital. He resigned that position in 1919 to become superintendent at the Pownal State School, which position he held until his death.

Dr. Vosburgh married Miss Ruth Partridge of Augusta, August 1, 1917. Two children were born to them, Ruth, who died some years ago, and Stephen Evert, a student at North Yarmouth Academy, of which Dr. Vosburgh was a trustee.

Dr. Vosburgh was a recognized authority on mental diseases and his opinion was often sought by groups dealing with such cases. He was a member of the American Medical Association, the Maine Medical Association, New England Psychiatric Association, American Psychiatric Association, was a 32nd degree Mason, a member of the New England Historical Genealogical Society, the Maine Historical Society, Sons of the American Revolution and the Torch Club of western Maine.

Dr. Vosburgh was interested in genealogy and stamp collecting, and with these hobbies he was accustomed to seek respite from the arduous work of his position at the school.

Notices

Committee on the Prevention and Amelioration of Deafness

A meeting of the Committee on the Prevention and Amelioration of Deafness was held in Portland on October 23, during the clinical session of the Maine Medical Association. At that time it was decided that the committee would do the following things:—

I. Write to Commissioner of Education Packard relative to offering a course of instruction on the hard of hearing at the summer normal school sessions.

II. Develop extension teams in line with the work being done in other branches of medicine thruout the state by the committee of which Dr. F. T. Hill is chairman.

III. Write to Parent-Teachers' Associations and service clubs offering speakers upon our subject.

IV. Develop a small exhibit at the June session of the Maine Medical Association in 1938.

HARRY BUTLER, *Chairman.*

1938 American Medical Association Meeting—San Francisco

When San Francisco was selected as the host city for the 1938 Annual Session of The American Medical Association, the profession of this Golden Gate Metropolis promptly initiated plans for the comfort, pleasure and entertainment of all who come to that national meeting. A local executive committee on arrangements, composed of five members, with Doctor Howard Morrow as General Chairman and Doctor Frederick C. Warnshuis as General Secretary, and eighteen sub-committees have been busy since July in developing plans and local arrangement details. Their objectives are the biggest, best, and most memorable annual session in the history of the American Medical Association.

Atlantic City, Kansas City, Cleveland, Detroit, with their known facilities and attractions, have been host cities in recent years, and have justified their selection as meeting places. However, and without disparagement, none of them possess the background, the setting, the resources, the history and romance, or the facilities that are found in San Francisco and in the great state of California —the Golden Bear Empire of the Pacific Coast. To reveal these, to extend California's and San Francisco's noted hospitality, and to cause those who plan to attend the 1938 session to experience ten days of profit and pleasure midst the environs of the annual meeting city, is the goal toward which the local profession is pointing.

The Local Committee on Arrangements cordially invites the profession of the country to be San Francisco's guests this coming June. Decide now to attend the 1938 American Medical Association Meeting and plan accordingly. During the coming months an insight to some of the feature functions will be disclosed, but the final details and program of events will not be revealed until you arrive. You will long regret it if you fail to attend the coming national meeting. Talk it over tonight with the good wife and your professional associates, and join the party of your state members that is coming to San Francisco—June 12 to 17, 1938.

The American Board of Internal Medicine Written Examination

The American Board of Internal Medicine will hold its next written examination on Monday, February 14, 1938, in various centers of the United States and Canada.

The examination will consist of two sessions of three hours each with the morning session held at 9.00 o'clock A. M., and the afternoon session held at 2.00 o'clock P. M.

The candidates who are successful in this written examination will be eligible to take the practical examination which will be held in San Francisco the Friday and Saturday prior to the opening of the Annual Session of the American Medical Association in June, 1938.

The final date for filing application for this written examination is January 15, 1938, and all applications should be in the office of the chairman before that date.

For further particulars and application blanks please address Dr. Walter L. Bierring, M. D., Chairman, American Board of Internal Medicine, Suite 1210, 406 Sixth Avenue, Des Moines, Iowa.

American Board of Obstetrics and Gynecology Examinations

The next examination (written and review of case histories) for Group B candidates who have filed applications will be held in various cities of the United States and Canada, on Saturday, February 5, 1938.

The general oral, clinical and pathological examinations for all candidates (Groups A and B) will be conducted by the entire Board, meeting in San Francisco, California, on June 13 and 14, 1938, immediately prior to the meeting of the American Medical Association.

Applications for admission to the June, 1938, Group A, examinations must be on an official application form and filed in the Secretary's office before April 1, 1938.

For further information and application blanks address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pa.

PAUL TITUS.

American Medical Association Council on Pharmacy and Chemistry

In addition to the articles enumerated in our letter of October 30 the following have been accepted:

Abbott Laboratories:
- Ampoules Sodium Cacodylate-Abbott, 0.05 Gm. (¾ grain), 1 cc.
- Ampoules Sodium Cacodylate-Abbott, 0.097 Gm. (1½ grains), 1 cc.
- Ampoules Sodium Cacodylate-Abbott, 0.2 Gm. (3 grains), 1 cc.
- Ampoules Sodium Cacodylate-Abbott, 0.324 Gm. (5 grains), 1 cc.
- Ampoules Sodium Cacodylate-Abbott, 0.454 Gm. (7 grains), 1 cc.
- Ampoules Sodium Cacodylate-Abbott, 0.975 Gm. (15 grains), 2 cc.

Gilliland Laboratories, Inc.:
- Gas Gangrene Antitoxin, Concentrated and Refined.
- Tetanus-Gas Gangrene Antitoxin, Concentrated and Refined.
- Antimeningococcic Serum, Concentrated and Refined.
- Rabies Vaccine (Modified Semple Method).

Lederle Laboratories:
- Aminophyllin-Lederle:
  - Ampuls Solution Aminophyllin-Lederle, 0.24 Gm., 10 cc.
  - Ampuls Solution Aminophyllin-Lederle, 0.48 Gm., 2 cc.
  - Tablets Aminophyllin-Lederle, 0.1 Gm. (1½ grains).

Paul-Lewis Laboratories, Inc.:
- Aminoacetic Acid-Paul-Lewis.

Rare Chemicals, Inc.:
- Salysal:
  - Salysal Tablets, 5 grains (0.3 Gm.).

E. R. Squibb & Sons:
Tablets Sulfanilamide-Squibb, 7½ grains.
Frederick Stearns & Co.:
Sterile Solution Neo-Synephrine Hydrochloride, 1 per cent 15 cc. vials.
John Wyeth & Brother, Inc.:
Vaginal Suppositories Silver Picrate-Wyeth, 1 grain (infant size).

Paul Nicholas Leech, *Secretary, Council on Pharmacy and Chemistry.*

Book Reviews

"Crippled Children—Their Treatment and Orthopedic Nursing"

By Earl D. McBride, B. S., M. D., F. A. C. S. Assistant Professor of Orthopedic Surgery, University of Oklahoma, School of Medicine; Attending Orthopedic Surgeon to St. Anthony Hospital; Associate Orthopedic Surgeon to Oklahoma City General and Wesley Hospitals; Visiting Surgeon to W. J. Bryan School for Crippled Children; Chief of Staff to Reconstruction Hospital, Oklahoma City, Okla.; Member of American Academy of Orthopedic Surgeons; in collaboration with Winifred R. Sink, A. B., R. N., Educational Director, Grace Hospital School of Nursing, Detroit, Mich.; Formerly Head Nurse of James Whitcomb Riley Hospital of the Indiana University Group; Instructor of Nurses, Indiana University School of Nursing; Educational Director, General Hospital, Mansfield, Ohio. Published by C. V. Mosby Co., St. Louis, 1937. Price, $3.50.

This very valuable book is now in its second edition. It has been well introduced, well received and continues to fill a need. It is a great help toward the understanding of the many causative factors which may lead to the many and various forms of physical deformity in children. This understanding alone, of course, satisfying as it might be to the investigator, would not be very satisfying to the individual child afflicted with a deformative process had it not become possible for the medical, surgical, psychologic and nursing branches of our profession to devise ways and means to remove some defects, correct others, re-educate mal-functioning members to more efficient and more harmonious coöperation.

Since orthopedic surgery consists chiefly of a highly specialized form of surgery and an equally highly specialized type of prolonged nursing, the authors describe in readily understandable language and demonstrate with the help of many excellent illustrations the various technics of procedure. These technics of orthopedic surgery, of orthopedic post-surgical nursing and of reconstructing and re-habilitating exercises are planned to enter or to restore the patient into his normally appropriate sphere in the community as a self-supporting citizen whenever possible.

This is a very valuable book to be used as a reliable guide by those physicians and nurses who are called upon to care for any who are afflicted with a correctible or improvable physical defect of the congenital or acquired varieties of malformation.

"Synopsis of Digestive Diseases"

By John L. Kantor, Ph. D., M. D., Associate in Medicine, Columbia University; Gastroenterologist and Associate Roentgenologist, Montefiore Hospital for Chronic Diseases, New York. Published by C. V. Mosby Co., St. Louis, 1937. Price, $3.00.

"This book is an attempt to present simply, clearly and concisely the essential facts concerning the diseases of digestion." It is of the same handy pocket size as the other members of the Mosby Synopsis series.

"Synopsis of Genito-Urinary Diseases," 2nd Edition

By Austin I. Dobson, M. D., F. A. C. S. Published by the C. V. Mosby Co., St. Louis, 1937. Price, $3.00.

This is one of the Mosby synoptic medical books. In this second edition the author has included several important improvements in therapeutic measures. There is a good deal of useful information in these pocket-sized books and, no doubt, they represent a convenience for the medical student and some practitioners.

"Synopsis of Gynecology," Based on the Textbook "Diseases of Women"

By Harry Sturgeon Crossen, M. D., F. A. C. S., and Robert James Crossen, M. D. 2nd Edition. Published by the C. V. Mosby Co., St. Louis, 1937. Price, $3.00.

The authors present the medical profession with the second edition of this pocket-sized synoptic description of gynecologic problems. Some of the extensive revisions of the text of the 8th edition "Diseases of Women" by the same authors are included, in abbreviated form, of course, in this new edition. While the medical students no doubt welcome this form of textbook, the practitioner certainly will wish to possess the larger work, namely, Crossen's "Diseases of Women."

"The Human Foot—Its Evolution, Physiology and Functional Disorders"

By Dudley J. Morton, Associate Professor of Anatomy, College of Physicians and Surgeons, Columbia University.

Published by Columbia University Press, Morningside Heights, New York. Published, 1935. Reprinted, 1937. Price, $3.00.

With "The Human Foot" the author delivers to the medical profession a highly scientific and very useful work of lasting quality. The historical development of the human foot from our pre-human ancestors is painstakingly described and generously illustrated. "The chief purpose of these studies has been to identify and to analyze the primary factors of functional disorders of the foot." And since "An insight into the evolutionary background of the human foot helps us to evaluate more accurately the characteristics of its normal structure and function," the author set out in his research excursion to supply the scientific data which will help us to attain this insight.

During the many years which the author has spent to discover and to accumulate these scientific truths, he also discovered that a phrase so often used by the men and women who sell us their shoes like "natural support for the arch" is one of many in which glibness overshadows accuracy, and unfortunately tends to promote erroneous ideas about the foot and its welfare.

We have here an honest attempt to develop a scientifically controlled method for the prevention of functional disorders of the human foot which is based upon scientifically conducted methods of investigation of the possible causes of such functional disorders.

Reviewed by MATTHIAS MARQUARDT, M. D.,
Augusta, Maine.

"Why We Do It"

An Elementary Discussion of Human Conduct and Related Physiology by Edward C. Mason, M. D., Ph. D., F. A. C. P., Professor of Physiology, University of Oklahoma School of Medicine, Oklahoma City. Published by the C. V. Mosby Co., St. Louis, 1937. Price, $1.50.

"Why We Do It" probably should never have been written under this title. With youthful enthusiasm the author strives to tell the world in 160 pages the causes of and cures for erroneous human behavior. Being an earnest student of mankind, Dr. Mason must know that there is more, much more at the basis of the behavior problems of men, women and children living in our present state of civilization than can be enclosed in a book of this size, or, in fact, in any book of any size.

"Your Diet and Your Health"

By Morris Fishbein, M. D. Editor, *The Journal of the American Medical Association;* Editor, *Hygeia, the Health Magazine.* Published by Whittlesey House, McGraw-Hill Book Co., New York, 1937. Price, $2.50.

This volume is one of the well-known Whittlesey Health Series. In it the author attempts in plain everyday language to clarify America's Food problems. He shows how common-sense methods of food selection and food preparation could and would keep every member of our national commonwealth in a reasonably buoyant, vigorous state of health at a reasonably low expense, probably less than fifteen dollars a week for a family of five. The most expensive ways of our living seem to be the ways of the food-faddists, of which there are all too many.

The author takes up one by one the various human food requirements and then points to the sources of the supply. Probably the greatest accomplishment of the author and the most significant feature of this book is the incorporation of valuable information concerning the so-called protective foods. Even though we all know a great deal about such substances as milk, fruits, vegetables, eggs, cod-liver oil, liver, meat, potatoes and bread, it is well to have someone of such high standing as the author tell us more about them and he certainly does it very well.

This book is written for everyone who has to solve problems of food and feeding. It will serve as a guide for physicians who like to talk to their patients in matters of diet. A healthy return to the simpler ways of living is a good habit and a habit which we all can indulge in.

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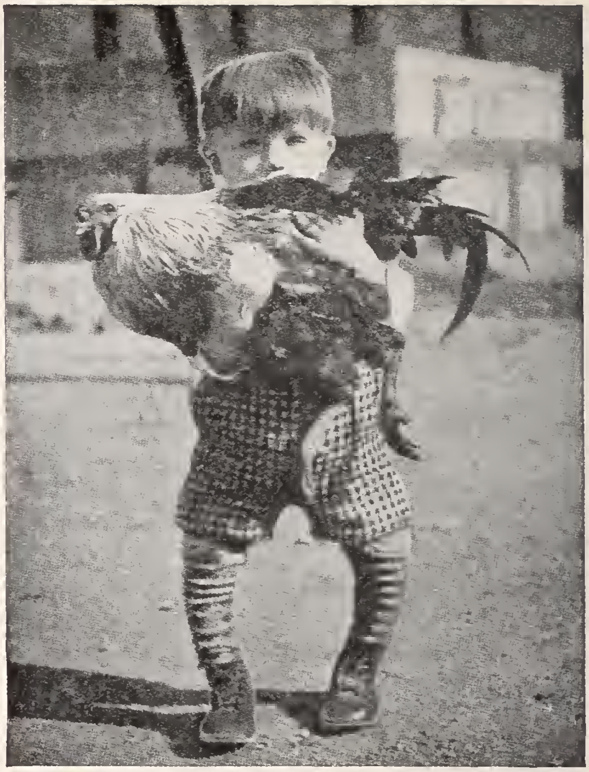

Example of severe rickets in a sunny clime. Courtesy of E. H. Christopherson, M.D., San Diego, and of "California and Western Medicine."

LEST WE FORGET—we who are of the vitamin D era—severe rickets is not yet eradicated, and moderate and mild rickets are still prevalent. Here is a white child, supposedly well fed, if judged by weight alone, a farm child apparently living out of doors a good deal. This boy was reared in a state having a latitude between 37° and 42°, where the average amount of fall and winter sunshine is *equal to that in the major portion of the United States.* And yet such stigmata of rickets as *genu varum* and the quadratic head are plain evidence that rickets does occur under these conditions.

How much more likely, then, that rickets will develop among city-bred children who live under a smokepall for a large part of each year. True, vitamin D is more or less routinely prescribed nowadays for infants. But is the antiricketic routinely administered in the home? Does the child refuse it? Is it given in some unstandardized form, purchased from a false sense of economy because the physician did not specify the kind?

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In contrast to the other vitamin deficiencies, cases of severe deprivation of the anti-pellagric factor are not uncommon in certain regions of the United States. It is also known that if the intake of food be drastically restricted for some reason—alcoholism, for example—pellagra may be encountered in localities in which the disease is not endemic (1). For these reasons, it is not unreasonable to suspect that subacute or latent deficiencies of the P-P factor may also be existent in this country.

In the absence of typical dermatitis, available means for the diagnosis of deficiencies of the anti-pellagric factor are not entirely satisfactory. The practitioner must rely upon a variable group of less specific symptoms such as glossitis, diarrhea, digestive disturbances, and nervous and mental disorders. However, consideration of these symptoms along with an evaluation of the diet upon which the subject had been maintained, may permit the conclusion that suboptimal intake of the P-P factor should be suspected.

The treatment of severe or perhaps even the mild manifestations of this dietary deficiency may require intensive therapy with food products or preparations known to be rich in the pellagra preventing factor. However, prevention of pellagra and maintenance of the cure appear to be largely matters of dietary regulation. In this connection, commercially canned foods deserve particular mention.

Goldberger and his associates directed considerable attention to evaluation of the pellagra-preventive powers of common foods. The values of foods, many of them canned foods, in the prevention of pellagra have been determined (2) by investigations in which human subjects were used.

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1. 1937. J. Am. Med. Assn. 108, 15.
1935. Ibid. 104, 1377.

2. 1934. U. S. Pub. Health Rpts.
49, 755.

This is the thirty-fifth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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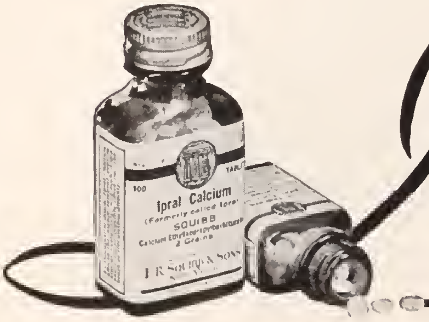

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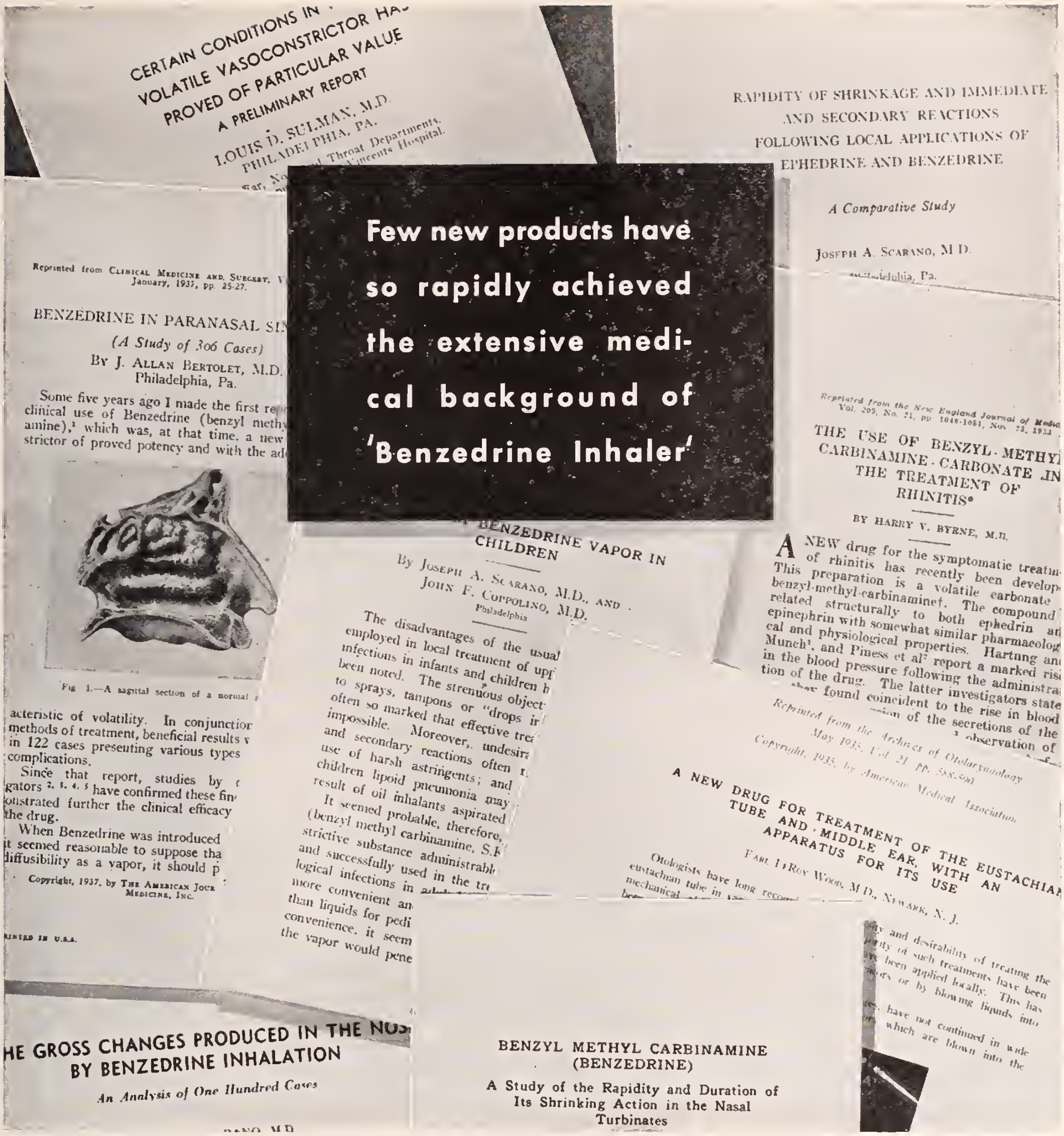

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A Comparative Study

JOSEPH A. SCARANO, M.D.
Philadelphia, Pa.

Reprinted from Clinical Medicine and Surgery, V
January, 1937, pp. 25-27.

BENZEDRINE IN PARANASAL SI
(*A Study of 306 Cases*)
By J. Allan Bertolet, M.D.
Philadelphia, Pa.

Some five years ago I made the first re clinical use of Benzedrine (benzyl meth amine),[1] which was, at that time, a new strictor of proved potency and with the ad

Fig. 1.—A sagittal section of a normal

acteristic of volatility. In conjunctior methods of treatment, beneficial results v in 122 cases presenting various types complications.

Since that report, studies by gators [2, 3, 4, 5] have confirmed these fin onstrated further the clinical efficacy the drug.

When Benzedrine was introduced it seemed reasonable to suppose tha diffusibility as a vapor, it should p

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BENZEDRINE VAPOR IN CHILDREN

By Joseph A. Scarano, M.D., and John F. Coppolino, M.D.
Philadelphia

The disadvantages of the usual employed in local treatment of upp infections in infants and children h been noted. The strenuous object to sprays, tampons or "drops ir often so marked that effective tre impossible. Moreover, undesir and secondary reactions often r use of harsh astringents; and children lipoid pneumonia may result of oil inhalants aspirated. It seemed probable, therefore, (benzyl methyl carbinamine, S.K strictive substance administrabl and successfully used in the tr logical infections in adult more convenient an than liquids for pedi convenience, it seem the vapor would pene

Reprinted from the New England Journal of Medic
Vol. 209, No. 21, pp. 1048-1051, Nov. 23, 1933

THE USE OF BENZYL-METHYL CARBINAMINE-CARBONATE IN THE TREATMENT OF RHINITIS*

BY HARRY V. BYRNE, M.D.

A NEW drug for the symptomatic treatm of rhinitis has recently been develop This preparation is a volatile carbonate benzyl-methyl-carbinamine†. The compound related structurally to both ephedrin an epinephrin with somewhat similar pharmacolog cal and physiological properties. Hartung an Munch[1], and Piness et al[2] report a marked ris in the blood pressure following the administra tion of the drug. The latter investigators state found coincident to the rise in blood of the secretions of the observation of

Reprinted from the Archives of Otolaryngology
May 1935, Vol. 21, pp. 588-590
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A NEW DRUG FOR TREATMENT OF THE EUSTACHIAN TUBE AND MIDDLE EAR, WITH AN APPARATUS FOR ITS USE

Earl LeRoy Wood, M.D., Newark, N. J.

Otologists have long recom eustachian tube in mechanical

y and desirability of treating the rity of such treatments have been been applied locally. This has ors or by blowing liquids into have not continued in wide which are blown into the

HE GROSS CHANGES PRODUCED IN THE NOS BY BENZEDRINE INHALATION

An Analysis of One Hundred Cases

BENZYL METHYL CARBINAMINE (BENZEDRINE)

A Study of the Rapidity and Duration of Its Shrinking Action in the Nasal Turbinates

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A VOLATILE VASOCONSTRICTOR

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INDICATED IN HEAD COLDS, SINUSITIS, HAY FEVER AND ASTHMA

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Maine Medical Journal

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Osteomyelitis of the Skull

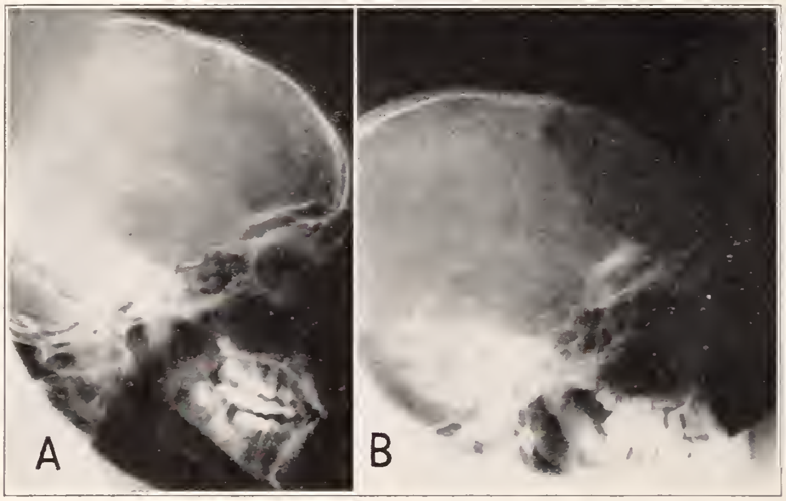
By Frederick T. Hill, M. D., Waterville, Maine

Osteomyelitis of the skull is fortunately a rare condition. When it does occur it always presents a dramatic picture — frequently a tragic one. No attempt will be made here to discuss the etiology, symptomatology, pathology, or bacteriology, as these have been thoroughly covered in the literature.

In 1913 McKenzie published the outstanding paper on this subject up to that time, quoting from the previous works of Tilley, Luc, Schilling and other investigators. He discussed the mode of invasion, stating that it could take place along the venous channels, as well as by direct extension. He recognized bone regeneration taking place after the activity of the process had subsided. He stated that extradural abscesses were to be expected. A sure diagnostic sign was edema, often some distance away. "The disease burrows like a mole in the earth and, like a mole, throws up mounds here and there as it goes along." He suggested distant trephining, and urged immediate and radical operation. "Wheresoever the disease has spread, there must the surgeon follow it."

Did McKenzie weaken his admonition for early and radical operation by attempting a differentiation between the discrete self-limiting type of the disease, and the diffuse, or spreading form? Munro says, "Actually the pathological process is fundamentally the same, the difference being due to the rapidity and extent of involvement of the venous channels in the diploe, and the resulting variation in the amount of bone destruction." Still there has been the impression that there were two distinct types and that if the discrete form could be diagnosed, a conservative policy would be advisable.

During the last ten, or twelve years, the necessity for early radical surgery in these cases has been stressed by a number of writers. Munro's studies definitely showed that the chances for recovery were much better with radical treatment than by a more conservative policy. In 1931, Furstenburg's paper, based upon clinical and pathological studies of 14 cases, was read before the American Laryngological, Rhinological and Otological Society. He clarified McKenzie's idea of venous extension by post-mortem findings of retrograde thrombosis and showed how extradural abscesses, separating the bone from the dura, favor extension of the osteomyelitis. He showed the necessity for radical removal of bone well beyond the obvious limits of the disease and presented evidence that bone regeneration, previously suggested by McKenzie, is a frequent occurrence, and that large portions of the skull can be removed without apprehension. In 1933, Mosher and Judd presented probably the outstanding paper of all time on this subject. Based upon histo-pathological studies, this paper stressed the practical importance of edema as a diagnostic sign and as a guide to the extent of bone to be removed. It defined quantitatively what McKenzie called "the obvious limits of the disease." It showed that the X-ray findings were from seven to ten days late and that the infection was from one to two inches beyond the area shown in the roentgenograms. In dramatic terms we were admonished to operate early and thoroughly. There was no equivocation and no qualifying statements. An ideal operative technique was outlined. Once the diagnosis was established there was no place for watchful waiting, on the chance that the process remain self-limited. "Osteomyelitis writes across the patient's brow, not only the diagnosis, but the treatment."



CASE NO. 1. A—Large diploic veins in frontal bone. No roentgenological evidence of osteomyelitis; yet operation revealed involvement almost to coronal suture, as well as a large epidural abscess.
B—Roentgenogram after operation showing extent of bone removal.

Case No. 1. (Seen in consultation in a neighboring hospital. While all the operations were performed by myself, she was not under my direct care until after the operation for osteomyelitis.) A girl of 14 years had developed severe frontal pain, with swelling of the lids of the left eye, following swimming. Temperature ranged between 101-102. The left middle turbinate was swollen. Roentgenograms showed cloudy left ethmoids. The ethmoid was opened intranasally and pus obtained. Four days later there was increased swelling of the eyelid. I was called again and a Lynch operation was performed. Necrotic bone was found at the inner upper angle of the orbit, and the frontal sinus contained pus. The lining was dark colored, friable and loosely attached. This was removed as gently as possible. When seen again four days later, there was a profuse nasal discharge, slight edema over the eyebrow and a temperature of 104.

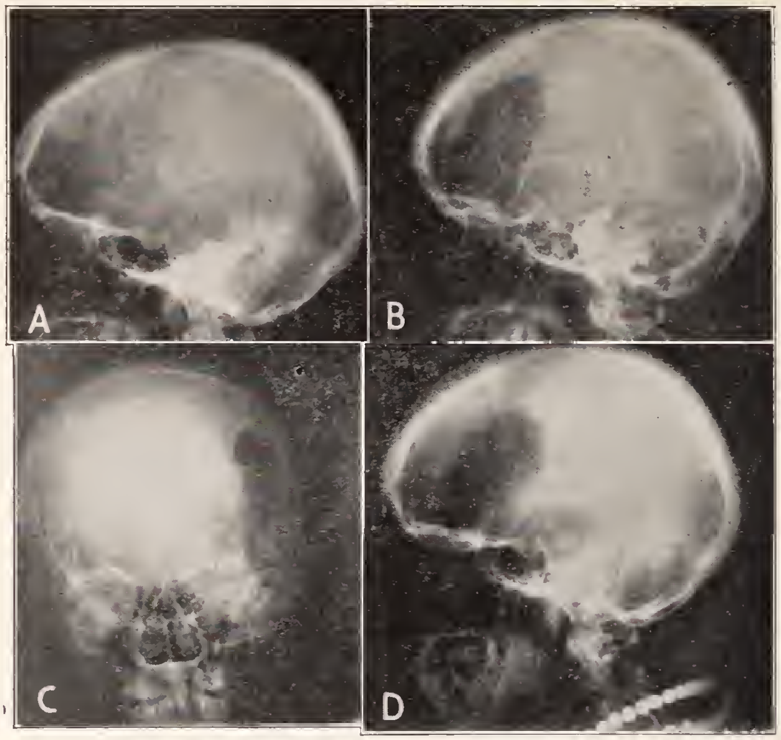
Roentgenograms showed no evidence of osteomyelitis. A revision of the frontal sinus was now done and pus found retro-orbitally. A rubber drain was inserted and the incision left open. Temperature dropped to normal and she seemed better.

Nine days later there was definite pitting edema, extending over the whole forehead to the hairline. While the X-ray still failed to show evidence of osteomyelitis, operation was immediately performed, using Mosher's reversed T incision. The bone was trephined, endeavoring to get beyond the area of involvement. This necessitated removing bone well back to the coronal suture and laterally into the left temporal fossa. A large epidural abscess was found to the left of midline. The flaps were sutured back, leaving the field open, and a blood transfusion given on the table. Culture showed a growth of streptococcus. Repeated cultures confirmed this.

In the first few weeks following operation she had several metastatic abscesses on the wrist and coccyx, followed by pneumonia at the left base. This had cleared and she seemed to be progressing favorably. Two months after the resection of the frontal bone, she developed headache, vomiting and a slight left facial weakness. Eyegrounds were reported as normal on repeated examinations. A definite bulging of the dura now became apparent. There was ankle clonus and a positive Babinski. Abdominal reflexes were abolished. There was incontinence of urine. Operation disclosed a large, fairly well-encapsulated abscess of the right frontal lobe. Overlying tissue was coned out with the cutting current and a Mosher drain introduced into the abscess cavity. She improved for about a month, and then began to show distinct personality changes, and became aphasic. Bulging was noted in the dura on the left side. The left frontal lobe was now explored, an abscess found, and a Mosher drain introduced. The patient failed rapidly from then on and died two weeks later, 50 days after the first operation for brain abscess, and 113 days after the resection of the frontal bone.

Permission for post-mortem examination could not be obtained. This patient showed a leukopenia throughout her illness, the highest white blood count at any time being 10,000.

This was a case of streptococcic infection, following swimming, in which the osteomyelitic process became well advanced; and in which, after it was apparently eliminated, there ensued a sequence of metastatic abscesses, pneumonia and brain abscess. The persistently low white count would seem to indicate a low resistance, yet she managed to survive this series of complications for a period of almost five months. Several writers, notably McKenzie and Woodward, have stated that streptococcic infections are apt to result fatally. In Williams and Heilman's recent paper they suggest, from the findings in two cases, that an anaerobic streptococcus may be the causative agent of this lesion. One very obvious handicap in the management of this case was the fact that she was in another hospital, not under personal observation and control at all times. The magnitude of the problem inherent in these cases makes any attempt at handling them, except under the most favorable circumstances, prohibitive. In reviewing the case, it would seem that draining the frontal externally, without closure, at the onset would have been preferable. Undoubtedly primary closure of the frontal incision may be a factor in the potential care of osteomyelitis. Whether the right frontal lobe abscess was not completely drained and itself invaded the left lobe, or whether this later manifestation was a second abscess is debatable. The virulence of the infection and the persistently low resistance of the patient are factors which must be kept in mind.



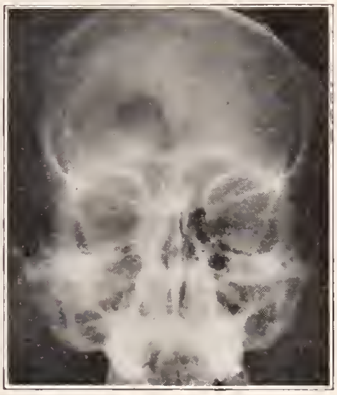
Case No. 2. A—Roentgenogram showing osteomyelitis, secondary to orbital abscess and having its inception in the temporal fossa.
B—Roentgenogram after operation showing extent of bone removal.
C—Anterior-posterior view of same case.
D—Roentgenogram nine months after operation showing beginning bone regeneration. Patient perfectly well—little deformity.

Case No. 2. This was a woman of 30 years, poorly developed and nourished, who had been admitted to the hospital July 21st on the Eye Service of Dr. H. F. Hill, with a diagnosis of orbital abscess. Examination at this time, quoting from the hospital records, showed, "Marked redness and swelling of both lids, definite proptosis, limited muscular movements, pupils 4 mm. in diameter and not reacting. The vitreus is hazy and the nerve head is just seen as a hazy blurred area. There is no vision and no light perception." Kahn and Hinton tests negative. Exploration of the orbit revealed considerable brawny induration but no pus. X-rays of the skull at this time were normal. She was extremely ill for some time, the temperature ranging between 101 and 102. Spinal puncture gave normal findings.

Apparently she was making a slow convalescence. Temperature had been normal for several days, when there was a sudden rise to 102. She was seen by Dr. T. E. Hardy of the Medical Service, who noted an area of pitting edema in the left temporal region, extending from the zygomatic arch upwards onto the scalp. He made a tentative diagnosis of osteomyelitis. She was then transferred to my service. Roentgenograms now showed a well-defined area of mottled osteomyelitis involving the temporal fossa. Under avertin anæsthesia a circular flap was made with the base down, somewhat similar to that used for a subtemporal decompression. The bone of the temporal fossa was completely necrotic, and pus and granulations were found coming from the orbit. The patient's condition precluded the ideal method of working from above downward, so it was necessary to remove the diseased bone as rapidly as possible, outward from the necrotic area. The dura was found covered with granulations. Removal of bone was continued until well beyond the diseased area. As is usual with these cases, there was considerable loss of blood. Two wide strips of Penrose rubber tubing were laid over the dura horizontally and the extreme upper edge of the circular flap was sutured back in place. This left a large tunnel extending from before backwards separating dura and periostium. She was given a blood transfusion. Culture showed a growth of staphylococcus aureus. The dressings were changed twice daily, endeavoring to keep the tunnel free and draining. She made a slow but uneventful convalescence from this time on. The flap healed without necessity of a secondary plastic and with little deformity. She was discharged from the hospital October 9th, 42 days after operation. She has been under observation since and has shown no signs of recurrence.

In this case the osteomyelitis was secondary to an orbital abscess. In Munro's study of 221 cases, ten were given as of this origin. Mosher has called attention to the extreme vulnerability of the external angle and temporal fossa of the frontal bone. This is well illustrated in this case.

In these two cases the diagnosis was made mainly upon the edema. Operation was performed immediately, without hesitation, once the diagnosis was made, and was carried out radically with wide resection of bone. Although the first patient died, apparently the osteomyelitic process had been eliminated. Transfusions were used in both cases post-operatively. The use of bacteriophage was considered in the last case, but she did so well with simple sterile dressings, changed frequently, that it was not resorted to.



Roentgenogram of case operated upon seventeen years ago, at which time a large portion of the frontal bone was removed. This shows considerable regeneration.

Unfortunately the necessity for differentiation between the types of the disease has seemed to be the first consideration in many case reports. If it is a matter of degree of activity, based to a certain extent upon the virulence of the infection and the resistance, age and type of bone in the individual, having made a diagnosis of osteomyelitis, it would seem most important to recognize the possibilities of diffusion early, rather than spend time and mental effort upon differentiation of types. Furstenburg has shown that spongy bone may be found in both the anterior and posterior walls of the frontal sinus, in close proximity to the lining membrane. Younger persons have more diploetic bone than do older people. This predisposes to diffusion of the process. With the possibilities of extension by retrograde thrombosis in mind, the appearance of edema, sepsis of varying degree and headache, in the presence of a suppurative sinusitis, certainly calls for immediate action rather than watchful waiting. Mosher's recent pathological studies show the extreme frequency of diploic veins in the frontal bone and their surprisingly large size. These can be traced upward, both inward to the dura and outward to the periosteum. They constitute almost open roads for the extension of infection by retrograde thrombophlebitis.

The literature of the last few years, especially the papers of Mosher and of Furstenburg, has greatly facilitated the management of osteomyelitis of the skull. Diagnosis is made easier and proper treatment indicated in definite terms. The significance of edema, the relative lateness of positive X-ray findings, and the necessity for immediate and radical operation have been stressed in a most impressive manner. While the activity of the process may vary, depending upon the virulence of the infecting organism and the resistance and age of the individual, so as to make possible, at times, a limited, sequestrating form of the disease, in the vast majority of cases, unless the chronic form is obvious, it would seem good judgment to operate radically, as soon as the diagnosis was established, especially in the younger individual.

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*Pneumatology**

(Anesthesia, Resuscitation, Oxygen Therapy)

By Paluel J. Flagg, M. D., New York City

Coördination, integration, the assembly of allied activities under a central control serves several purposes. It makes the personnel and equipment designed for the occasional emergency easy to find and functionally active. It provides routine work of sufficient volume to warrant the maintenance of adequate personnel. By the assembly of a number of activities looked upon as of minor importance, it proposes a group which collectively becomes of major significance.

For example, suppose that a patient in the medical ward suddenly develops an acute asphyxia from idiosyncrasy to morphine. Who is called to treat her? Suppose that a case of CO poisoning or submersion is brought into the accident ward. Who upon your Staff is trained and qualified to treat such an accident? If a neonatal asphyxia develops, who, because of experience in this field, is prepared to meet the emergency? Is the resident physician, the ambulance surgeon, or the pediatrician, by virtue of his special training, qualified to prevent asphyxial death?

When oxygen therapy is indicated for pulmonary cardiac or other complications, is the physician in charge familiar with the behavior of gases, and the mechanism used? Or must he depend upon the assistance or the direction of the technician supplied by the commercial firm providing the equipment?

Is there not a common denominator which normally ties up these two apparently isolated activities, resuscitation and oxygen therapy? It would seem that the vital factor in each case is that gases are used for therapeutic purposes, to save life in the first instance, to treat clinical disease in the second. While these activities are vital and must be met as they occur in a manner in keeping with modern medical findings, the volume of each or their combined volume is scarcely sufficient in the average hospital of 100 to 200 beds to warrant a department with separate personnel and equipment.

However, there is another activity proceeding as a routine in the surgical service of every hospital, a routine which depends upon the use of gases for the control of pain, which employs nitrous oxide and oxygen, ethylene, ether, chloroform†, cyclopropane, etc. We refer, of course, to anesthesia. While the objection may be advanced that many general anesthetics are carried on by spinal, local and basal anesthetics, it is only necessary to call to mind what would happen to the surgical field if all anesthetic gases were suddenly eliminated. A survey of the hospitals of metropolitan New York sometime ago suggested that gases formed the background of more than 90% of all the general anesthesias administered. It is not at all unlikely that a survey of the six thousand hospitals in the United States would substantiate this reaction.

Let us consider the personnel employed in the anesthetic field. We find that the physician alone, or the physician in control of one or more nurse technicians, constitutes the Anesthetic Department. This personnel has one outstanding qualification which differentiates it from the balance of the hospital Staff. *It is intimately familiar with the management of the unconscious patient.*

Curiously enough, unconsciousness, whether deliberately induced by anesthesia or artificially induced by one of the many causes of asphyxiation, each presents an anatomical and physiological state which is, for practical purposes, identical.

Granted that these facts are true, is it not logical that the personnel responsible and intensively trained in the routine use of gases for the control of pain should also be held responsible for the routine use of gases for the treatment of clinical disease and the emergency use of gases for the saving of life? That such integration has actually taken place in a number of University clinics but serves to confirm the logical necessity of such an integration.

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† Vapors are gases in practice.

* Read before the Knox and Sagadahoc County Medical Societies, August, 1937.

It would appear, however, that in order to popularize such organization, in order that those in charge of these emergencies may turn instinctively to the anesthetist for skilled assistance, something must be done to eliminate the natural resistance offered by the terminology, Anesthesia. To attempt to combine anesthesia, resuscitation, and oxygen therapy under the generic term anesthesia is to beg the question. Why should the anesthetist, a man whose business it is to put people to sleep, be called to treat carbon monoxide poisoning, submersion, asphyxia neonatorum, drug poisoning, or a terminal polio about to die from asphyxia, and yet his training qualified him thoroughly to do so? What is there in the terminology, anesthesia, which implies skill in saving life outside of the immediate surgical field? To attempt to popularize the anesthetist as a man specially trained to care for oxygen therapy and resuscitation is to deprive the appeal of its major force, a force which recognizes him as expert in the use of gases. To attempt to becloud the issue by combining anesthesia, resuscitation and gas therapy is like comparing walnuts, hickory nuts, and just nuts.

Gas therapy as a generic term unites in a logical manner the separate activities of anesthesia, resuscitation and oxygen therapy. As a scientific terminology, however, it cannot become generally adopted for it does not permit the suffix, ology, denoting science.

Fortunately, however, there is a scientific term, already in use, which covers exactly the meaning implied. This term is "Pneumatology."

Pneumatology. The science dealing with air or gases, their physical and chemical properties, and among other things their therapeutic application. Stedman, 12th Edition, 1934, page 853.

Pneumatology. The science of gases and their therapeutic application. Lippincott's new Medical Dictionary, 3rd Edition, page 751.

Pneumatology. The sum of what is known regarding gases and air and their therapeutic application. American illustrated Medical Dictionary, Dorland, 1925, page 898.

The effect of the adoption of Pneumatology as a generic terminology to include anesthesia, resuscitation and oxygen therapy would be to provide a highly trained personnel, familiar with the behavior of gases and their therapeutic usefulness. This personnel constantly active by reason of the employment of gases for the control of pain is prepared and expert in the treatment of emergencies which now receive little or no attention.

The adoption of such a terminology would automatically provide instruction and control of technicians now employed in the administration of gases, technicians active as rescue squads, employed in the emergency saving of life, and technicians employed to care for oxygen therapy apparatus. The adoption of such a terminology would serve to rehabilitate a morale, badly shaken by the confusion which now exists in the public mind between the physician, administering anesthetics and the nurse-technician. It would, by providing certain cases such as emergency resuscitations under the full control of the anesthetist, overcome the unavoidable inferiority complex which has resulted from a continuous association as assistant to the operating surgeon.

Since the adoption of the terminology, Pneumatology, offers little if any opportunity to protect the livelihood of the physician so engaged, owing to the fact that the emergency saving of life and the management of oxygen therapy has not been established on a fiscal basis, it is not to be expected that physician-anesthetists as a class can carry the burden and initiate such an integration. Initiation must be taken by the Medical Board or the Board of Trustees of the hospital who, because of the substantial decrease in morbidity and mortality, will recognize the urgent necessity for assisting in the subsidation of such a department.

As the problem is distinctly one of public welfare and inasmuch as it proposes to assist by coördination and supervision the technicians now employed by the municipality in its police and fire departments by industry, and by the utilities, is it too much to hope that these agencies may be induced by reason of their public health program to promote and to contribute to such subsidation? When it becomes clear to these agencies that the problem of emergency rescue is intimately tied up with the problem of instruction and prevention, as well as intelligent transportation and hospitalization immediately following the accident, that such continued service can only be secured by a properly organized and trained personnel, is it too much to hope that an active coöperation will be enlisted?

Finally, when it is recalled that there occurs regularly in the United States a mortality of 1000 a week from asphyxiation, the need for such organization becomes a present emergency.

*Chest Conditions Secondary to Empyema of the Posterior Para-Nasal Sinuses**

By Harry Butler, M. D., Bangor, Maine

There has been so little written and so little said upon the subject of those conditions of the tracheobronchial tree, and of the lung which have their genesis in posterior ethmoidal and sphenoidal empyema, that it seems logical to present this subject for discussion before such a group as we have here. I say, advisedly, empyema of the posterior ethmoids and sphenoids since pathology of the other para-nasal sinuses is pretty apt to be detected by physician or patient. It is that type of sinus pathology in which only post-nasal discharge is a symptom, which is so generally overlooked as a source of cardiac or respiratory disorder. It is unfortunate that so few of these cases come to the attention of the otolaryngologist, except as a last resort. Early recognition and treatment would shorten the course of the patient's suffering, if it were otherwise, and prevent such irreparable damage as results in bronchiectasis or valvular heart lesions. Much has been written upon the subject of intracranial and extracranial complications of sinusitis, but little upon chest complications, which are so much more frequent. In general the medical man and the medical writer is much more familiar with the foci of teeth, tonsils, gaul bladder, and so forth, and much pioneer work must be done in bringing them to a state of sinus consciousness with respect to trouble in more distant organs. The present medical school teaching seems to be cognizant of this fact, for the recent practitioner seems far more familiar with the sinuses as a source of infection, than his elders, even than those of my own period of medical instruction. This is heartening. Also there is a growing evidence that the pediatrician is becoming conscious that sinuses are developed to quite an extent in his charges, and that these anatomical structures must be treated with suspicion. It is essential that this consciousness grow, since the greatest danger of all in overlooking post-nasal discharge is in the young, their elders being often conscious at least that they have "catarrh."

While this is not a pathological conference, but a clinical meeting, it would seem wise to touch at least briefly upon the modus operandi of infections secondary to sinus disease; or rather upon the schools of theory, as little work has been done to trace the pathways of infection. It is felt that the causes are two-fold, anatomical and pathological. Gravity and aspiration certainly are a factor, while lymphatic and hematogenous transmission cannot be ruled out. While leaning toward the anatomical school, the speaker feels that on the pathological side, hematogenous or embolic transmission is the more dangerous source, since the lymphatic defense mechanism is so great that less danger of the arrival of toxic material seems probable by this route. It is not within the scope of this paper to trace out the lymphatic drainage of the para-nasal sinuses, yet it might be stated that the lymphatics of the sinuses drain chiefly into the retropharyngeal group of lymph nodes, thence to the deep cervical nodes, and from there to the large veins at the base of the neck, thus establishing continuity of pathway for infective material from the sinuses to the right heart and thence to the lungs, there to become held in capillaries.

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* Read before Piscataquis County Medical Society on November 18, 1937.

Upon the aspiratory side may it be said of deep-seated resultant infection, that Wintermitz has proven that the lymphatics of the tracheal submucosa establish direct pathways of infection to the lung by anastomosing with the periarterial and peribronchial lymphatics at the bifurcation of the trachea. Since the direct connection between the lymphaties of the nose and sinuses has *not* been proven to provide anastomosis with those of the lung, it seems probable that the aspiratory is the worse source of secondary infections. Pal has observed that many asthmatics fluctuate directly with their sinus conditions, but does not attempt to establish lymphatic or aspiratory pathways. Whatever the avenue of infection, it remains a clinical fact that once a secondary focus is established, the longer it remains before care of the diseased sinus is undertaken, the more prolonged is both general and special therapy necessary. Therefore it behooves us to preach and practice early diagnosis of possible foci in the less frequently recognized sinus conditions.

The question arises as to why certain cases of chronic sinusitis develop the various signs of secondary infection, while others escape. The general powers of resistance of the patient, and the virulence of the organisms affecting the original sinus focus, must be the answer. It may be stated that streptococci, pneumococci and the Klebs-Loeffler bacilli are the worst offenders in the production of secondary lesions of the heart and tracheobronchial tree.

For some years I have been intensely interested in those cases of overlooked sinusitis whose only local symptom may be post-nasal discharge, or a glistening, dry posterior pharyngeal wall. These patients may have a thorough physical examination from every other point of view, but for some reason treatment of their respiratory tract has not been improved noticeably. Gradually men are becoming suspicious of some deep-seated sinus difficulty and the patients are more frequently appearing. Many types of cases are seen, and they are very satisfactory many times from a therapeutic point of view, for they show very marked improvement after relatively little local treatment. Most interesting of all, perhaps, are the children whom we see sent in because of a chronic cough associated with no demonstrable lung pathology; those children who have asthmatic attacks, whether of the bronchial asthma or the asthmatic bronchitis type associated with or without cough; and those children whose only difficulty seems to be the worry of physician and parent caused by persisting cervical adenitis. Examination of these children is frequently negative from the otolaryngologist's point of view until search of the posterior sinus system is undertaken. They have no nasal discharge or running noses, they breathe perfectly through their noses, and on examination show no collections of pus above the middle turbinate, and transilluminate perfectly clearly. Examination of the throat may show some post-nasal discharge or dryness of the posterior pharyngeal wall, but in many cases, until positive drainage of the ethmoids is instituted, nothing will be found. Positive drainage will frequently produce a surprising amount of purulent content. Usually the cough diminishes in a very few days under treatment, and in those cases in which the sinusitis has been cleared up, the cough, in my experience, has never returned. One of the most trying conditions in children is found in those patients with bronchial asthma with its associated expiratory difficulty, or those with what might be termed an asthmatic bronchitis where the chief dyspnœa is inspiratory. These youngsters do, in many cases, give final evidence of a posterior sinus infection, and improve tremendously under treatment.

The President's Page

TO THE MEMBERS OF THE MAINE MEDICAL ASSOCIATION:—

A report of the Cancer Work in the State of Maine, in 1937, has lately been received from the Chairman of the State Cancer Committee, Dr. Forrest B. Ames, of Bangor.

We have five Cancer Clinics in the State, one in Portland, two in Lewiston, two in Waterville and one in Bangor.

That the doctors of the State, as well as the laity, will avail themselves more and more of these Clinics is confidently expected and desired.

It is the first year we have had the facilities to properly care for those who were unfortunate enough to be afflicted with malignancy. These Clinics are a Godsend to those who are not able to pay for skillful diagnosis and treatment.

Since August, 1936, some 357 individuals have received investigation or treatment, or both.

For our population this is a small number as compared with the number that probably should have sought investigation, and treatment, and will do so in the future.

About three-quarters of the patients, who presented themselves to the Clinics, were found to be malignant.

This figure includes all cases, whether the patients came themselves, or were referred by their physicians.

The doctors of Maine can have every confidence in the personnel of the Clinics. They are persons who are intensely interested in their special work, they are using the latest diagnostic methods, and they are employing the most efficient methods of treatment, which includes the use of X-ray, radium and surgery, and are constantly endeavoring to improve the service.

It will be about four years hence before we can tabulate the end results.

The Scannell Memorial Fund has been very wisely and judicially administered, by the Women's Field Army, for those patients who are not able to pay.

The late bulletin of the Women's Field Army shows the large number of patients assisted.

Every county in the State is represented except Knox.

This service is so worthy and important it should receive the hearty coöperation of every Member of the Maine Medical Association.

One of the greatest unsolved problems of medicine is the specific cause of cancer.

Thousands of research workers, all over the world, are bending every energy to this task.

One of these research units is the Roscoe B. Jackson Memorial Laboratory located in Bar Harbor, Maine, and under the efficient directorship of Dr. Clarence C. Little.

Mice are used for the experimental work, of which there are about 50,000. This little animal is used because its life span is only two years, and it breeds every three weeks, so that many generations can be investigated in a few months.

Very definite and significant facts concerning malignancy have been discovered in this laboratory, and many interesting problems are now being developed.

Dr. Little extends an invitation to the Members of the Maine Medical Association to visit this laboratory during our Annual Convention in June.

RALPH W. WAKEFIELD, M. D.

Editorial

Organized Medicine and the Care of the Indigent Sick

One of the accepted principles of organized medicine, State or National, is to provide all that is possible for the sick, and these are not idle words. Much as there is to do, progress has been made, yet one would not contemplate it in a vainglorious attitude, but more to ask, whether what now seems a fact is merely a belief and whether as a profession we have refused to accept the vast changes in our social and economic security. The stand patter in medicine is numerically few; the radical is in likewise proportion, and while there are charlatans and a despicable minority that is the burden of all professions, it can safely be said that the majority of physicians are deeply and personally concerned in bringing the best possible skill to those who are ill. The miserable men paraded in a novel now having a certain degree of popularity in this country, it first was published in Great Britain, have their counterparts in law, banking or any other profession; but one may ask, in all sincerity, what is to be gained by emphasizing an evil that all know exists. For quite some time organized medicine has been the subject of articles in the lay press, many of them emanating from sources that seem distinctly hostile to it, carrying the inference and sometimes the direct word that as a profession it has failed to live up to its responsibilities and public duty.

Medicine is not organized on the order of trade unions, commendable as the aims of many of them are, yet it does and will oppose now, as in the past, any attempt to commercialize practice or commit the profession to bureaucratic or political control. It does so with the full knowledge that the health and well-being of the people of this nation will be better served if the mutual and confidential relationship between doctor and patient remains undisturbed. One commentator regards this relationship as a farce, which is, of course, his privilege. To build any sound economic structure requires mutual confidence between architect and artisan; to tear down and disrupt that which we have, without careful consideration what to replace it with, means destruction. One sometimes wonders if we have forgotten what a Democratic Government really is. Measures proposed to promote the public good cannot be best framed by those with an axe to grind, pressure groups or those whose experience hardly warrants they have valid judgment.

One might infer from the welter of words poured out regarding the care of the indigent sick that such care was the absolute charge and obligation of the medical profession, and that it had bogged down and had either refused to perform its duty or was even incompetent. Very, very few hospitals in this country are under direct medical control. Government or privately controlled institutions constitute our hospital set-up and today, as never before, many hospitals are operating under financial conditions absolutely beyond their control. Hospitals are obliged to use something for money, and but with few exceptions no remuneration is made to the professional visiting staff. True, in some instances, full-time physicians are employed at a salary, but such employment is obligatory to insure that the hospital be able to carry on its daily work. A reasonable belief might exist that a betterment in business conditions might lessen the charity load on hospitals. People gainfully employed at a *living* wage might better be able to assume their financial obligations in whole or part, and while medicine gladly assumes its share of deserving charity service, the reduction of the costs of hospital care for the poor and those of moderate circumstances is a problem for hospital executives to fathom. Surely this is a dark picture to face if one felt that common sense had departed entirely from the people of this country, yet someone has said that common sense is the least common of the senses. Local, State and Federal governments furnish many things for the protection of the health and safety of us all. This is made possible by taxation and from which funds certain allotments are levied. Is it unreasonable to feel that the medical profession should be relieved of its forced disproportionate contributions to charity and that the care of the indigent sick should be assumed by government, local or State, with the assurance that the medical profession will do its part, not only as members of a profession. but as American citizens?

Committee on Graduate Education

Commonwealth Fund Post-Graduate Medical Fellowships

The Commonwealth Fund of New York City is making available fellowships in the subjects indicated below to members of the Maine Medical Society, to be given at Harvard Medical School, Courses for Graduates, 25 Shattuck Street, Boston, Massachusetts.

Medicine, given at the Massachusetts General Hospital, Peter Bent Brigham Hospital or Boston City Hospital. A group of at least six must take the course at one time. Such a group may be made up from any or all of the four States in which the fellowships are offered, namely: Maine, New Hampshire, Vermont or Massachusetts.

Pediatrics, given at the Children's Hospital. Not more than six may take the course at one time.

Obstetrics, given at the Boston Lying-In Hospital. Not more than six may take the course at one time.

Office Surgery, given at the Boston City Hospital; designed for physicians engaged in general practice; subjects studied are surgical problems met in the office; instruction in the out-patient department. A group of at least six must take the course at one time.

Fellowships are for one month. Preference will be given those who take the course in medicine, for a second month in medicine or in obstetrics, pediatrics or office surgery, when fellowships are available during succeeding years. The stipend is $250.00 plus tuition and an allowance of $25.00 for travelling expenses.

Qualifications: Applicant must be a graduate of a grade "A" medical school; a member of the Maine Medical Society in good standing; must have been in practice at least five years and should preferably be under forty-five years of age; and must be a resident of a community of less than 10,000 population. Application blanks may be obtained from the Division of Public Health, The Commonwealth Fund, 41 East 57th Street, New York City, or from Dr. F. R. Carter, the Secretary of the Maine Medical Association, 22 Arsenal Street, Portland, Maine.

Frederick T. Hill, M. D.,
Chairman, Committee on Graduate Education.

Cancer Committee

Cancer Work in the State of Maine in 1937

Reports at hand from Cancer Clinics in the State show evidence of an increasing number of patients studied and treated. Over-lapping dates of reports received make a composite study of more value than a listing of cases from individual institutions. For example, one group report covers dates from August, 1936, another from November, 1936, and two others begin reports in 1937. However, the group study offers a few figures of general interest.

Between the dates reported, a total of about 357 individual patients received study or treatment, or both, in the five Cancer Clinics throughout the State. The total number of examinations or treatments is not available, but most of the cases reported for more than one Clinic visit and the number of treatments varied with the individual patient.

An average of 74% of the patients who came to the Clinics received a positive diagnosis of malignancy. Diagnosis was arrived at by the combined methods of clinical examination by members of the various clinic groups; examination by X-ray in obscure cases; and a large number of biopsies. Final diagnosis was well established before treatment was advised or begun.

Types of cases covered the average variety with malignancies of the breast, cervix and uterus, lips and mouth predominating.

Methods of treatment used show that the Clinics in the State are well organized along accepted lines. Recognition is being given to the latest and most accepted fundamental methods for successful treatment of malignancy. I refer to the general use of radium, X-ray and surgery, alone or in various combinations subject to close coöperation between the Radiologists and Surgeons.

A word should be included about the work of the Women's Field Army and the disbursement of their donation, the Scannell Memorial Fund. Following is a copy of the bulletin recently released by the secretary and distributed among the physicians of the State.

Facts and Figures of the Scannell Memorial Fund

Number of cases treated	113
Number of Counties represented (Androscoggin, Aroostook, Cumberland, York, Franklin, Somerset, Waldo, Hancock, Sagadahoc, Washington, Kennebec, Oxford, Penobscot, Lincoln, Piscataquis. Knox not included)	15
Number of communities represented	100
Number of Radium treatments	34
Number of X-ray treatments	629
Number of X-ray diagnoses	17
Number of men receiving treatment	49
Number of women receiving treatment	64
Number treated in each Clinic:	
Maine General Hospital	56
Central Maine General Hospital	19
Eastern Maine General Hospital	25
St. Mary's General Hospital	13
Number direct to Clinics	27
Number referred by family physician	77

Types of Cancer Treated

Jaw	1	Thyroid	1
Uterus	8	Eye	2
Cervix	21	Buttocks	1
Breast	12	Heel	1
Lip	22	Prostate	1
Anus	1	Vulva	1
Skin	1	Eyelid	1
Face	5	Gland, neck	1
Groin	1	Leukemia	3
Sinus	1	Hodgkins	4
Shoulder	1	Abdominal tumor	1
Bladder	1	Nose	2
Pigmented mole	1	Penis	1
Ear	2	Tonsil	4
Forehead	2	Lung and Liver	1
Mouth	2	Liver	1
Intestine	1	Colon	1
Kidney	2		
		Total	112

The educational work of the Women's Field Army has contributed greatly toward the present interest in cancer work in the State as a whole.

From a study of reports received from the various active Cancer Clinics in the State of Maine the following summary and conclusions may be presented:

1. An increasing number of patients is being referred to Cancer Clinics for diagnosis and advice.

2. To date about 74% of the cases have been found to show signs of malignancy.

3. Treatment has been instituted by request of the family physician and the coöperative use of Radium, Surgery and X-ray has been carried out by the specialists in charge.

4. The Scannell Memorial Fund, disbursed by the Women's Field Army, has aided appreciably in securing X-ray and Radium treatments for the medically indigent. The 1938 campaign should receive hearty coöperation from the medical profession.

Forrest B. Ames, M. D.,
Chairman Cancer Committee,
Maine Medical Association.

County News and Notes

Androscoggin

Androscoggin County Medical Society Annual Meeting, January 20, 1938

Meeting called to order at 8.40 P. M. at Auburn Y. M. C. A.

Minutes of the last meeting approved as read.

No report was forthcoming from the Fee Schedule Committee.

Dr. L. A. Sweatt read a report as against the acceptance of the forms as issued on Vital Statistics, as having certain questions which may later place the physician in a possible legal entanglement. Motion was made by Dr. Green to accept this report of the committee, and was so carried.

A report brought in by Dr. Haskell, read by the secretary, was in favor of accepting the "standing orders" as issued for the local Red Cross Nursing Staff, and was so carried by the society.

At this time a report on the treasury and secretarial results was read by the secretary and accepted.

Following which Dr. H. L. Gauvreau, the retiring president, read a paper on "Fractures," which was well received.

Dr. Gauvreau then appointed the following committee to bring in nominations of officers for the ensuing year: Drs. W. H. Haskell, L. O. Roy and W. W. Bolster. The following officers were elected for the following year:

President: L. A. Sweatt.

Vice-President: L. P. Gerrish.

Secretary-Treasurer: A. E. Peters (re-elected).

Delegates and Alternates (to Annual State Meeting): Elected for 2 years: Dr. W. E. Webber. Present status of delegates and alternates: Drs. W. L. Haskell (1939), A. W. Plummer (1939), W. E. Webber (1940) (re-elected). Alternates: Drs. Henry Sprince, E. J. Marston, Blinn W. Russell (all re-elected).

Councilor elected: Dr. H. L. Gauvreau. Present status of county councilors: Drs. J. Gottlieb (1939), W. W. Bolster (1940), H. L. Gauvreau (1941).

Committee on Public Relations: Drs. R. A. Goodwin, H. W. Garcelon, G. Rand (all re-elected).

Meeting adjourned at 10.35 P. M.

Respectfully submitted,
A. E. Peters, M. D., *Secretary.*

Report of Secretary, January 20, 1938, Annual Meeting

We had eight regular meetings of the society for the year 1937, omitting but one meeting date in October when the Clinical Session held in Portland came on the same date, with due notices being sent at the time. Otherwise, the meetings have been held as prescribed by the By-Laws.

In the arrangement of programs for the year it was thought desirable to develop two important phases so far as this society was concerned, 1) to include local men together with those from outside the state for papers in order to develop material of local editorial value, and 2) to establish a closer union of fellowship amongst the members and definite concertive interest in matters medical occurring within our jurisdiction and the State Association. This I feel has been somewhat started on the road to accomplishment but continued improvement is essential in attendance and interest to establish the county society as the medical spokesman in our community. We have had as main speakers, Dr. Carl M. Robinson of Portland, who spoke on "Gall Bladder Problems," Dr. Henry Sprince on "Functional Bleeding in the Female," Dr. M. S. F. Greene on "Pre- and Post-Operative Care," Dr. Augustus Riley of Boston on "Pain in the Kidney Region," Atty. Herbert E. Locke on "Medico-Legal Problems," together with a very pleasant meeting arranged in recognition of men who had been graduated 35 years or more in our community. With all these meetings local men had some part either in the main or as discussers, at the same time bringing in men from nearby counties to enhance the interchange of ideas. I feel we have done something along this phase.

We have had no great disbursement from the treasury during the year to accommodate speakers with any luxuries. Dr. Riley has been the only one to receive expense fees of $10.00, and therefore in consideration of reports in previous years it was felt in order that the society share as a whole in some of the conserved funds utilized when the 35-year recognition program was given. The recommendation is made that this policy be pursued in the future.

We started the year 1937 off with 72 members. We have lost Dr. C. A. Sprague, Dr. C. A. Norton and Dr. C. H. Cunningham during the year. New members added were Drs. L. A. Parrella, R. E. Williams, C. C. Thomas and W. E. Viles. Only three members were dropped by the secretary because of non-payment of dues, one of whom has already paid to be re-instated for 1938, another will come in as soon as the bills are sent out, one who has not been heard from, and another who is still not in good standing.

During the past year the Constitution and By-Laws of the society has been thoroughly gone over with amendments, copies sent to all members, and more are available for those who want them.

The secretary at present has available the records of the society back to 1917 only, and the original Charter is still absent. Recommendation is made that these be correlated in the near future as it is one of the essentials of the secretary in his keeping and for which he is responsible for so far as the State Association is concerned.

In conclusion the secretary wishes to express his thanks to the other officers for their suggestions and coöperation during the year, and that the officers of 1938 will see a growth in the principles that will make the Androscoggin Medical Society an important factor where it belongs so far as local or state medical circles are concerned.

Respectfully submitted,
A. E. Peters, M. D., *Secretary.*

Oxford

Through the courtesy of the Bingham Associates Fund, a clinic was held at the Rumford Community Hospital, January 12, 1938.

4.00 to 5.30. Ward Walks.

6.30. Dinner at Hotel Harris.

Lecture by Dr. Samuel Proger, Boston, Massachusetts.

Subject: *Obesity.*

About thirty members and guests were present.

J. S. Sturtevant, M. D., *Secretary.*

Piscataquis

On January 1st there arrived at the Office of the Secretary-Treasurer of the Maine Medical Association a check covering *the full membership* of the Piscataquis County Medical Society. Such prompt coöperation merits deserving thanks and they are most cordially extended.

Sagadahoc

The regular meeting of the Sagadahoc County Medical Society for January was held at the Hotel Sedgwick on Wednesday, January 19, 1938, at 6.30 p. m.

President Pratt of Richmond presiding.

Those present were Drs. Snipe, Kershner, Fuller, Joss, Bailey, Day and Winchenbach.

Drs. Belknap of Damariscotta, Fuller of Pemaquid, Richardson, Stetson and Webb of Brunswick were visitors and Dr. Ellingwood of Rockland, our councilor, was a guest.

Dr. George Young of Skowhegan presented a very interesting and instructive program on Thoracic Surgery.

The dinner was an excellent one and as usual a very excellent evening was enjoyed.

Francis A. Winchenbach, *Secretary.*

York

The annual meeting of York County Medical Society was held at the Webber Hospital, Biddeford, January 5, 1938, at 2.00 P. M. Dinner was served at the Thacher Hotel at 1.00 P. M.

Election of officers: Nominating committee: Drs. Cobb, Prescott and Stimpson.

President: W. H. Kelly, M. D., Sanford.

Vice-President: D. B. Mayo, M. D., South Eliot.

Secretary-Treasurer: C. W. Kinghorn, M. D., Kittery.

Delegate to 1938 Annual Meeting: E. C. Cook, M. D.

Alternates to 1938 Annual Meeting: E. M. Cook, M. D., and C. W. Kinghorn, M. D.

Secretary's and Treasurer's reports were read and accepted.

Drs. Cobb and Ross were appointed as a committee to draw up resolutions on the death of Percy H. Abbott, M. D.

Oscar Perrault, M. D., was admitted to membership.

Program: Demonstration of Obstetrical Methods as Outlined by the National Society, Roland B. Moore, M. D., Portland.

Respectfully submitted,
C. W. Kinghorn, *Secretary.*

The Annual Report, 1937

As usual four quarterly meetings were held. The annual meeting was held at the Chadbourne House, January 6, 1937. Officers were elected. There were fourteen members and nine guests present. The program, a Symposium on Physical Therapy, was conducted by Drs. Lowry and Green of Boston.

The second quarterly meeting was held at the Goodall Hospital in Sanford, April 17th. A clinic was conducted by the Sanford physicians. There were fourteen members and eight guests present.

The summer meeting was held at Dr. Hill's summer home at Biddeford Pool, August 18th. This was a joint meeting with Cumberland County.

The fall meeting was held at the Tavern, Kennebunk, October 6th. A Symposium on Obstetrics, conducted by Dr. Roland Moore, and papers by Drs. McGill and Foster composed the program. There were fifteen members and six guests present.

During 1937 the Society has lost four members: Two removed to other counties; Dr. Allen, who has since died, retained his membership in another State, thereby being unable to belong to York County; and Dr. Percy H. Abbott, who died in October.

The Society has a paid-up membership of 47 members and three honorary members in comparison to 50 members and one honorary member in 1936.

The average attendance at the meetings was fourteen and seven guests, the total average attendance being higher than that of 1936.

Respectfully submitted,
C. W. Kinghorn, *Secretary.*

New Members

Oxford

George E. Sullivan, M. D., Oxford, Maine.
George I. Gould, M. D., Andover, Maine.

York

Oscar Perrault, M. D., Biddeford, Maine.

Removal Notice

Donald G. Wight, M. D., formerly of Westbrook, has moved to 438 Cottage Road, South Portland, Maine.

Necrologies

Percy Hobbs Abbott, M. D.

Upon the tenth of October, nineteen hundred and thirty-seven, Percy Hobbs Abbott, M. D., of Waterboro, Maine, died from a recurring attack of apoplexy. He had been practically disabled for months, due to a previous attack.

Doctor Abbott was born in Waterboro, Maine, April seventeen, eighteen hundred and eighty-five. He attended the Waterboro schools, and then went to Portland High School, from which he graduated. He then attended Maine Medical School, and received his degree in nineteen hundred and ten. He served one year as Interne in the Maine General Hospital in Portland, and then started practicing in Goodwin's Mills. He stayed at Goodwin's Mills from nineteen hundred and twelve to nineteen hundred and fourteen, when he went to Waterboro, where he practiced medicine until his death.

Doctor Abbott belonged to the Grange, the Odd Fellows, and the Masons, besides the County, State, and the American Medical Societies. He was Selectman of Waterboro for five or six years, and Health Officer of the town during practically his entire practice in the town. He leaves a widow and six children.

WHEREAS: The Divine Providence has summoned from our membership Doctor Percy Abbott, *Be it resolved*, that in the death of Doctor Abbott, the York County Medical Society has lost a valuable member, the Medical Profession, a very competent Physician, the Community in which he lived and served, a valued citizen, his patients, a true friend and medical counsellor.

Be it further resolved: That a copy of these resolutions be spread upon the records of this Association, and that a copy be forwarded to his widow and children.

S. A. COBB,
H. D. ROSS,
Committee on Resolutions,
York County Medical Society.

Albert Parsons Heald, M. D.

Dr. Heald died at his home in Thomaston, November 2, 1937, at the age of 76, of cerebral hemorrhage. He had been in failing health following a fall on an icy crossing while making an emergency call last January.

He was born in Searsmont, Maine, February 14, 1861, the son of Dexter and Abigail Heald, and was the youngest of their twelve children. He received his preliminary education in the public schools of Searsmont, Rockport and Camden, and his medical education at the University of Vermont Medical School, from which he graduated in 1884. Following his graduation he practiced medicine for a short time in each of the following towns: Jefferson, Washington, and Union, before locating in Thomaston in 1890, where he remained until his death.

Dr. Heald was an honorary member of the Maine Medical Association, a Fellow of the American Medical Association, and a member of the Alumni Association of the University of Vermont.

Notices

Pathological Conferences

Clinical Pathological Conferences were instituted at the *Maine General Hospital, Portland*, on January 19th and will be held in the Laboratory on the following dates: February 16, March 2, March 16, March 30, April 13, April 27, May 11, May 25. *These are open to all physicians.*

Women's Field Army

Edward H. Risley, M. D., of Waterville, chairman of the Advisory Board of the Women's Field Army, Maine Division of the American Society for the Control of Cancer, announces the appointment of Mrs. Louise H. Wells of Portland, as field secretary. She will assist with the work of organizing units in the unorganized sections of the State and will also check on patients treated in the several clinics.

For the past five years Mrs. Wells has been admitting officer and credit manager of the Maine General Hospital in Portland, and prior to that was field secretary for the War Savings Department. She is a charter member of the Altrusa Club of Portland.

From now until the end of April Mrs. Wells will take an active part in the preliminary program of plans for the second annual enlistment and educational campaign which is to take place the first week in April. The entire month has been officially designated throughout the Nation as Cancer Control Month.

*Tumor Clinics**

Portland: *Maine General Hospital*, Thursday, 11 a. m.-12 m. Director, *Langdon T. Thaxter, M. D.*

Lewiston: *Central Maine General Hospital*, Tuesday, 11 a. m.-12 m. Director, *E. V. Call, M. D.*

St. Mary's General Hospital, Wednesday, 4 p. m. Director, *R. A. Beliveau, M. D.*

Waterville: *Thayer Hospital*, Thursday, 9 a. m.-11 a. m. Director, *Edward H. Risley, M. D.*

Sisters Hospital, Thursday, 9 a. m.-11 a. m. Director, *Blynn O. Goodrich, M. D.*

Bangor: *Eastern Maine General Hospital*, Thursday, 11 a. m.-12 m. Director, *Magnus F. Ridlon, M. D.*

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* Approved by Maine Medical Association.

Crippled Children's Service

Lewiston: *Central Maine General Hospital*, 9-11 a. m., 1-3 p. m., Saturday, February 26th, March 26th, April 30th, May 28th, June 25th.

Portland: *Children's Hospital*, 9-11 a. m., 1-3 p. m., Monday, February 14th, March 14th, April 11th, May 9th, June 13th.

Bangor: *Eastern Maine General Hospital*, 1-3 p. m., Thursday, February 17th, March 17th, April 21st, May 19th, June 16th.

Maine Hospital Association

The annual meeting of the Maine Hospital Association was held December 17, 1937, at the Central Maine General Hospital in Lewiston, Maine. The meeting was held in the morning with Dr. Joelle Hiebert presiding. Lunch was served to all remaining at the hospital, also at the St. Marie's Hospital in Lewiston, Me.

During the business meeting the constitution and by-laws that had previously been prepared were read and discussed and with the necessary changes were approved and accepted. Fifteen hospitals were represented in the attendance.

The following officers were elected for the ensuing year: President, Joelle C. Hiebert, M. D., of the Central Maine General Hospital, Lewiston, Me.; Vice-President, Stephen Brown, M. D., of the Maine General Hospital, Portland, Me.; Secretary and Treasurer, Margaret A. Hebert, R. N., of the Gardiner General Hospital, Gardiner, Me.

Margaret A. Hebert, R. N.,
Secretary-Treasurer,
Maine Hospital Association.

Rules Governing the Award of "The Foundation Prize" of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons

(1) "The award which shall be known as 'The Foundation Prize' shall consist of $500.00."

(2) "Eligible contestants shall include only (a) internes, residents, or graduate students in Obstetrics, Gynecology or Abdominal Surgery, and (b) physicians (with an M. D. degree) who are actively practicing or teaching Obstetrics, Gynecology or Abdominal surgery."

(3) "Manuscripts must be presented under a nom-de-plume, which shall in no way indicate the author's identity, to the Secretary of the Association together with a sealed envelope bearing the nom-de-plume and containing a card showing the name and address of the contestant."

(4) "Manuscripts must be limited to 5,000 words, and must be typewritten in double-spacing on one side of the sheet. Ample margins should be provided. Illustrations should be limited to such as are required for a clear exposition of the thesis."

(5) "The successful thesis shall become the property of the Association, but this provision shall in no way interfere with publication of the communication in the Journal of the Author's choice. Unsuccessful contributions will be returned promptly to their authors."

(6) "All manuscripts entered in a given year must be in the hands of the Secretary before June 1st."

(7) "The award will be made at the Annual Meetings of the Association, at which time the successful contestant must appear in person to present his contribution as a part of the regular scientific program, in conformity with the rules of the Association. The successful contestant must meet all expenses incident to this presentation."

(8) "The President of the Association shall annually appoint a Committee on Award, which, under its own regulations, shall determine the successful contestant and shall inform the Secretary of his name and address at least two weeks before the annual meeting."

Jas. R. Bloss, M. D., *Secretary*,
418 Eleventh St., Huntington, W. Va.

Opportunity for Physicians to Tour America En Route to the Convention

The thought that the forthcoming A. M. A. Convention in San Francisco, June 13th to the 17th, is such a splendid opportunity for a tour of the United States both going out and coming back, has inspired definite action. The coöperation of more than 25 state medical societies has made it possible to arrange a special train tour which will include such outstanding highlights of the North American continent as the Indian Detour, the Grand Canyon, Los Angeles, Riverside and Santa Catalina Island—on the way out to San Francisco. A choice of two return routes are possible, one of which visits the charming cities of Portland, Seattle, Victoria and Vancouver and the beautiful scenic spots of the Canadian Rockies; the second route travels via Yellowstone National Park, Salt Lake City, Royal Gorge, Colorado Springs, and Denver.

There is an all-inclusive price for this tour which includes transportation from home-town to home-town, though the tour starts officially at Chicago on Monday, June 6th, from which point an American Express escort joins the group, as this travel company has been appointed transportation agent and the business details of the trip are in their capable hands.

Return Route No. 1. We shall visit Portland, Oregon, famed as the city of roses, and enjoy as well a drive along the noted Columbia River Highway. Seattle is next, and here we also cover all the points of interest, including both the Lake and Sound districts. Now the Canadian part of our journey begins, and we sail by comfortable steamer to the cities of Victoria and Vancouver, where we do sightseeing. Now a train takes us into the enchanting scenic regions of the Canadian Rockies, and we stop at Chateau Lake Louise. Our drives through the heart of the Rockies take us to Moraine Lake, the Valley of Ten Peaks, Johnson Canyon, and finally to Banff, where we make another stop-over. After additional sightseeing around Banff, we entrain for Chicago.

Return Route No. 2 takes us to Chicago in a more southerly route. A 3½-day tour of Yellowstone National Park is one of the highlights of this tour. We also see the Grand Canyon of the Yellowstone and Mammoth Hot Springs. Salt Lake City is on our itinerary, which gives us an opportunity to visit Saltair Beach on Great Salt Lake, also the Great Copper Mills and Smelters. Our next call is at Colorado Springs. Our travels in the Rockies take us up to the summit of Pike's Peak, to the Garden of the Gods, to Seven Falls, and finally to Denver. This lovely city is a center for outings in the Rockies, and we are soon off on a 65-mile tour of Denver Mountain Parks, including Memorial Museum and Tomb of Buffalo Bill of western fame. From Denver we travel to Chicago.

The above is barely a glimpse of the outline of the tours, but it is hoped that some idea has been given of the enjoyable travel awaiting those physicians and their families and friends, who wish to combine attendance to the Convention with an interesting journey and a happy vacation.

American Medical Golfing Association

The American Medical Golfing Association's Twenty-fourth Annual Golf Tournament will be held in San Francisco, California, on Monday, June 13, 1938, at the San Francisco Golf and Country Club.

A "Golfers' Special" to the A. M. A. Meeting is being sponsored by the American Medical Golfing Association. Six games of golf have been arranged on the trip to the Coast, in New Orleans, Houston, Galveston, San Antonio, Los Angeles and Del Monte; and three on the return journey through Portland, Seattle, Vancouver, Lake Louise and Banff.

Non-golfers as well as golfers, and their ladies, are welcome on the "Golfers' Special."

For full particulars on the A. M. G. A. Tournament or the "Golfers' Special," write the President of the A. M. G. A., Dr. Walt P. Conaway, 1723 Pacific Avenue, Atlantic City, New Jersey.

Graduate Instruction

Information regarding graduate instruction can be obtained from any member of the committee: F. T. Hill, Chairman, Waterville; Norman Nickerson, Greenville; and Julius Gottlieb, Lewiston. *Application blanks* are available at the office of the State Secretary, Frederick R. Carter, 22 Arsenal St., Portland, and will be promptly furnished on request.

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Book Reviews

"The Traffic in Health"

By Charles Solomon, M. D., Assistant Clinical Professor of Medicine, Long Island College of Medicine; Lecturer in Materia Medica, Training School for Nurses, Jewish Hospital of Brooklyn. Author of "Pharmacology, Materia Medica and Therapeutics, Prescription Writing and Formulary —The Art of Prescribing."

Published by Navarre Publishing Company, Inc., New York, 1937. Price, $2.75.

At last the professional as well as the lay reader is presented with a general survey of our patent medicine industry. At the hand of numerous illustrative case records, the author shows how the manufacturers and promoters of this type of merchandise make use of the spoken and written word to arouse an epidemic-like fear in the public. This fear in turn produces a state of confusion and a feeling of helplessness which makes the uninformed a ready victim of this form of "infection." Words which are loaded with demonic meanings readily produce panic-like behavior. The sound or sight of such terms as halitosis, acidosis, athlete's foot, B. O., etc., etc., generate a tyranny of thought of such magnitude that the author feels that "the success of so many idiotic nostrums and brazen charlatans seem to argue that no amount of education will permanently eradicate the craving of the public for magic, for the mysterious, and for the unorthodox." He believes that we are here dealing with a disease of industry and of society.

He presents in this volume the etiological factors, the pathological symptoms and attempts to show the possibilities of successful therapeusis. He appeals to the medical profession and among them especially to those who master the arts of speaking and writing and hopes that they eventually can convey the scientific factual information to the members of their own profession, to the members of the pharmaceutic and the dental professions as well as to the intelligent laymen. He believes that "an educated public cannot be deluded." However, as physicians we are confronted perhaps, more than any other profession, with the unalterable fact that since human expression of all forms, verbal, graphic, pictorial, or structural in any form whatever, is apt to be colored by each individual's experiences and meanings and any known remedial agent will have to be selected according to the individual's present needs if any reasonable amount of universal good is to be obtained.

"Materia Medica, Toxicology and Pharmacognosy"

By William Mansfield, A. M., Phar. D., Dean and Professor of Materia Medica and Toxicology, Union University, Albany College of Pharmacy, Albany, N. Y.

Published by the C. V. Mosby Co., 1937. Price, $6.75.

According to the preface, " 'Materia Medica, Toxicology and Pharmacognosy' is a text and reference book on the therapeutics, toxicology, pharmacognosy, and posology of the official drugs of the United States Pharmacopœia XI and the National Formulary VI."

There are 202 full-page illustrations of roots, rhizomes, tubers, barks, flowers, leaves and fruits, etc., etc. Several of the illustrations show chiefly the burlap container and shipping case in which the drugs are contained but little of the drug itself is visible. It is this reviewer's opinion that in future editions these illustrations should be replaced by truly representative ones of equally good quality as the others. It seems that this book would appeal most strongly to those physicians who like to possess a pictorial representation of the drugs they use or who like to show to their patients the pictures of the crude drugs which go to make up their prescriptions. It is quite a showy volume but probably not sufficiently thorough-going for a great many practitioners, especially those who are driven to employ the newer drugs which are continuously brought before them, either through the advertisements of their professional journals or by requests from those of their patients who have tried the old and found it wanting and now demand that something new be tried. The radio-informed patient of today tends to choose therapeutic agents which appeal to him most strongly and the wise physician is he who keeps up with his patient in the march through time.

"Administrative Psychiatry"

By William A. Bryan, M. D., Superintendent Worcester State Hospital, Worcester, Mass.

Published by W. W. Norton & Co., Inc., New York, 1936. Price, $3.50.

It is always a pleasure to read and re-read "books that live." Dr. Bryan has created such a book under the title stated above. The ideal standards aimed at in "Administrative Psychiatry" are high; so high, in fact, that the book probably will serve as a guide for many years to come for all administrators, whether they are in charge of tens, hundreds, or thousands of individuals which are grouped together for definite reasons and purposes. The principles outlined and elaborated in this remarkable book first of all are directed towards modern care and welfare of the population housed within the jurisdiction of the administrator of institutions designed for the mentally ill of our states and nation. So sound and far-reaching are these suggested plans, rules and regulations for better administration that any head of any organization, who has the welfare of those men, women and children, for whose well-being he is responsible by virtue of his position, at heart, can benefit immensely by the diligent study and application of the working plans as they are laid out by the author. At any rate, "Administrative Psychiatry" is, in the opinion of this reviewer, of such comprehensive value that every library of every institution which cares for the mentally ill ought to contain a copy of this book.

"MacLeod's Physiology in Modern Medicine"

Edited by Philip Bard, Professor of Physiology, Johns Hopkins University School of Medicine, with the collaboration of Henry C. Bazett, Professor of Physiology, University of Pennsylvania; George R. Cowgill, Associate Professor of Physiological Chemistry, Yale University School of Medicine; Harry Eagle, Past Assistant Surgeon, United States Public Health Service, and Lecturer in Medicine, Johns Hopkins University School of Medicine; Chalmers L. Gemmill, Associate in Physiology, Johns Hopkins University School of Medicine; Magnus I. Gregersen, Professor of Physiology, College of Physicians and Surgeons, Columbia University; formerly Professor of Physiology, University of Maryland School of Medicine; Roy G. Hoskins, Director of Research, Memorial Foundation for Neuro-endocrine Research; Research Associate in Physiology, Harvard Medical School; J. M. D. Olmsted, Professor of Physiology, University of California; Carl F. Schmidt, Professor of Pharmacology, University of Pennsylvania.

Published by the C. V. Mosby Co., St. Louis, 1938. Eighth edition. Price, $8.50.

In the eighth edition, "Physiology in Modern Medicine" has become a really useful and comprehensive book in which may be found deposited a large amount of accumulated knowledge pertaining to the physiological processes, etc., in man. The book is written specifically for the practicing physician who wishes to keep informed on the progress made in recent years, both in the physiological laboratory for animal experimentation as well as in the clinical laboratory for the study of human functional behavior. Two kinds of type were employed in the making of this book. The regular type is used for all the generally informative material; the smaller type is reserved for descriptions of specific methods, for data which might be judged by some to be of secondary importance but which are nevertheless very important and necessary for a full understanding of the subject matter under discussion, for the treatment of such matters which are still controversial, and lastly, for the entry of material which is chiefly of clinical interest.

As a whole, the entire work is well constructed. The informative material is understandingly presented in all sections with the possible exception of that dealing with the special senses. This is a handicap, especially for such owners of the book among the general practitioners who have to deal with post-accidental complications which may involve some real or imaginary derangement of one or more of the special senses. He would like to find information concerning the normal function of these senses in his physiology.

The editor makes it very clear that this book is not an exhaustive compilation. The various authors brought together as much as they could bring within the limits of a textbook. Works of this type are meant to be collective, authoritative and perhaps generally stimulative. Those readers who wish to inform themselves more thoroughly in certain specific fields of research in physiology will find numerous authors cited in the forty-eight pages of references appended to the general text.

"Surgical Pathology of the Diseases of the Neck"

By Arthur E. Hertzler, M. D., Surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas; Professor of Surgery, University of Kansas.

Published by J. P. Lippincott Co., Philadelphia, Montreal and London, 1937.

This is the ninth of the famous Hertzler's Monographs on Surgical Pathology. The previously published volumes of this series bear the following titles: "Surgical Pathology of the Diseases of Bones," "Surgical Pathology of the Skin, Blood-vessels, Muscles and Nerves," "Surgical Pathology of the Genito-Urinary Organs," "Surgical Pathology of the Female Generative Organs," "Surgical Pathology of the Mammary Gland," "Surgical Pathology of the Peritoneum," "Surgical Pathology of the Gastro-Intestinal Tract," "Surgical Pathology of the Thyroid Gland." The tenth monograph, entitled "Surgical Pathology of the Mouth and Jaws," is promised to appear soon.

In the preface, the author states, "To the surgeon the neck is the most interesting region of the whole body. Nowhere else is it so convincingly demonstrable that there is a vast difference between surgical pathology and the pathology of surgical tissue. It is perfectly obvious, of course, that the disease begins before either the patient or surgeon is aware of its existence. The study of the disease should begin at the earliest moment that its presence is recognized. . . . The present tendency to treat all lesions of the neck by irradiation without a definite pathologic diagnosis is to be deplored. What surgeons have learned is in grave danger of being lost by this practice."

The author then evolves his work by beginning with a preview of the surgical affections of the neck. Since "the surgical diseases of the neck comprise a wider range than those of any other region of the body," and since "nowhere is the futility of trying to know everything better exemplified than in writings dealing with the diseases of this region," the author tries to present in this book the results of his findings which he accumulated while studying many cases in the clinic throughout the course of the several disease entities. With the help of 206 excellent illustrations he describes the nature and progress of the various primary and secondary new-growths, as well as the inflammatory affections of the neck. It seems that every physician interested in surgery would like to include this work, together with the others by the same authors, in his library.

"An Introduction to Dermatology"

By Richard L. Sutton, M. D., Sc. D., LL. D., F. R. S. (EDIN.), Professor of Dermatology, University of Kansas School of Medicine, and Richard L. Sutton, Jr., A. M., M. D., L. R. C. P. (EDIN.), Instructor in Dermatology, University of Kansas School of Medicine.

Published by the C. V. Mosby Co., St. Louis, 1937. Price, $5.00.

This small volume of 666 pages is now in its third edition. There have been added forty-five new illustrations which bring the total number up to 229.

There has been a great deal of progressive work done in this medical specialty during the past decade. However, in spite of all our advances it seems that our most modern researches lead us to a form of knowledge which leads us back to the old standards of simple living whenever we expect to enjoy the fullest possible success of our therapeutic agents. Properly selected food which is thoroughly masticated, appropriate moderate exercise, sufficient amounts of reasonably pure fresh drinking water, sunny living, working and sleeping rooms which are well ventilated, abstinence from alcohol, tobacco, coffee, tea and other substances employed for self-medication are found to do just as much good for us as they did for our predecessors; this is wisely restated by the authors.

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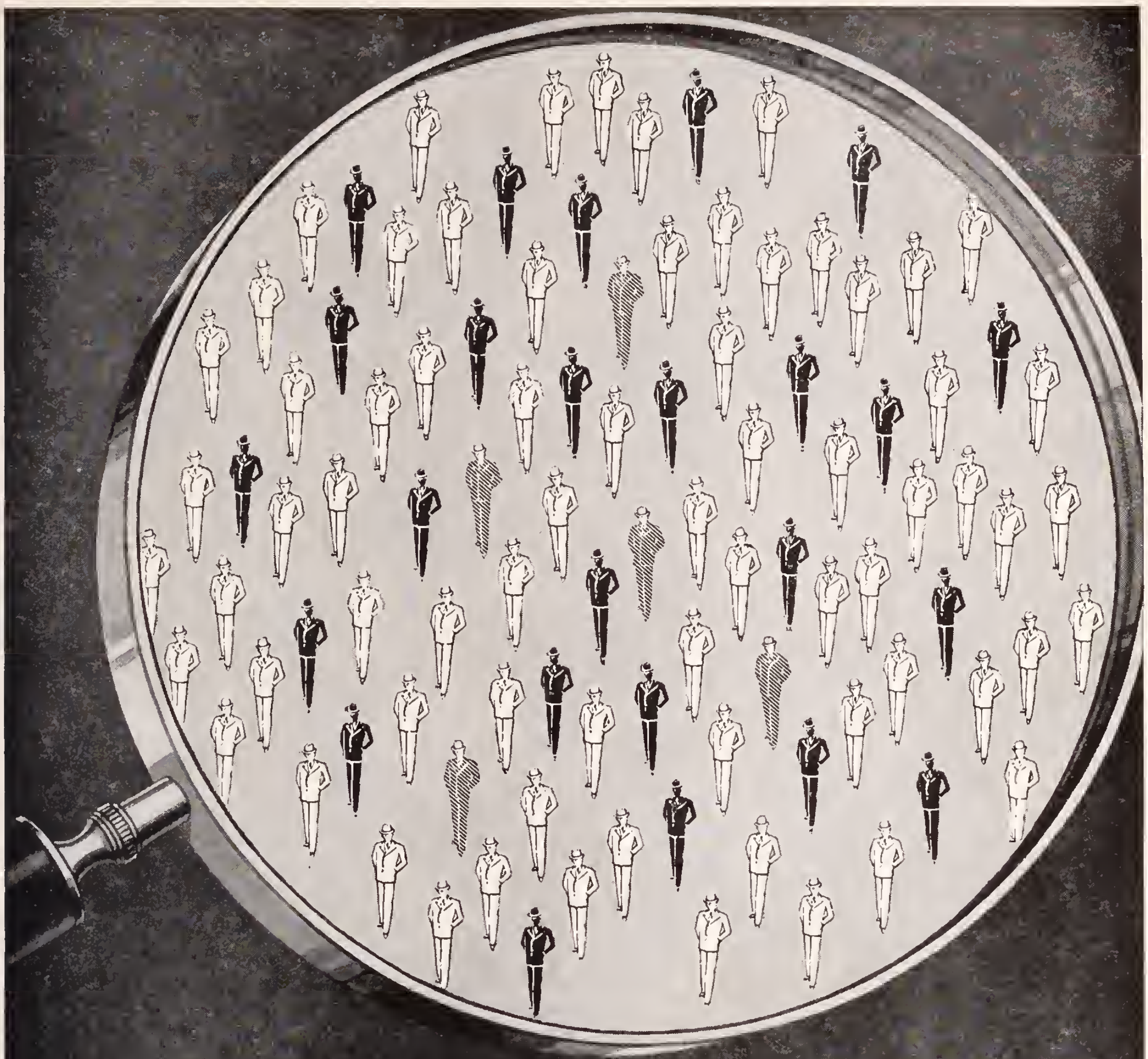

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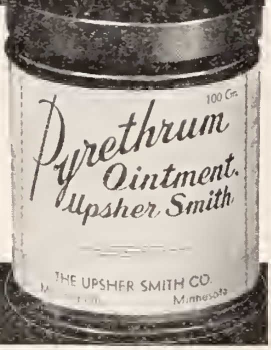

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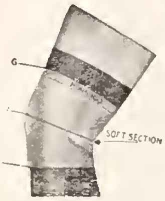

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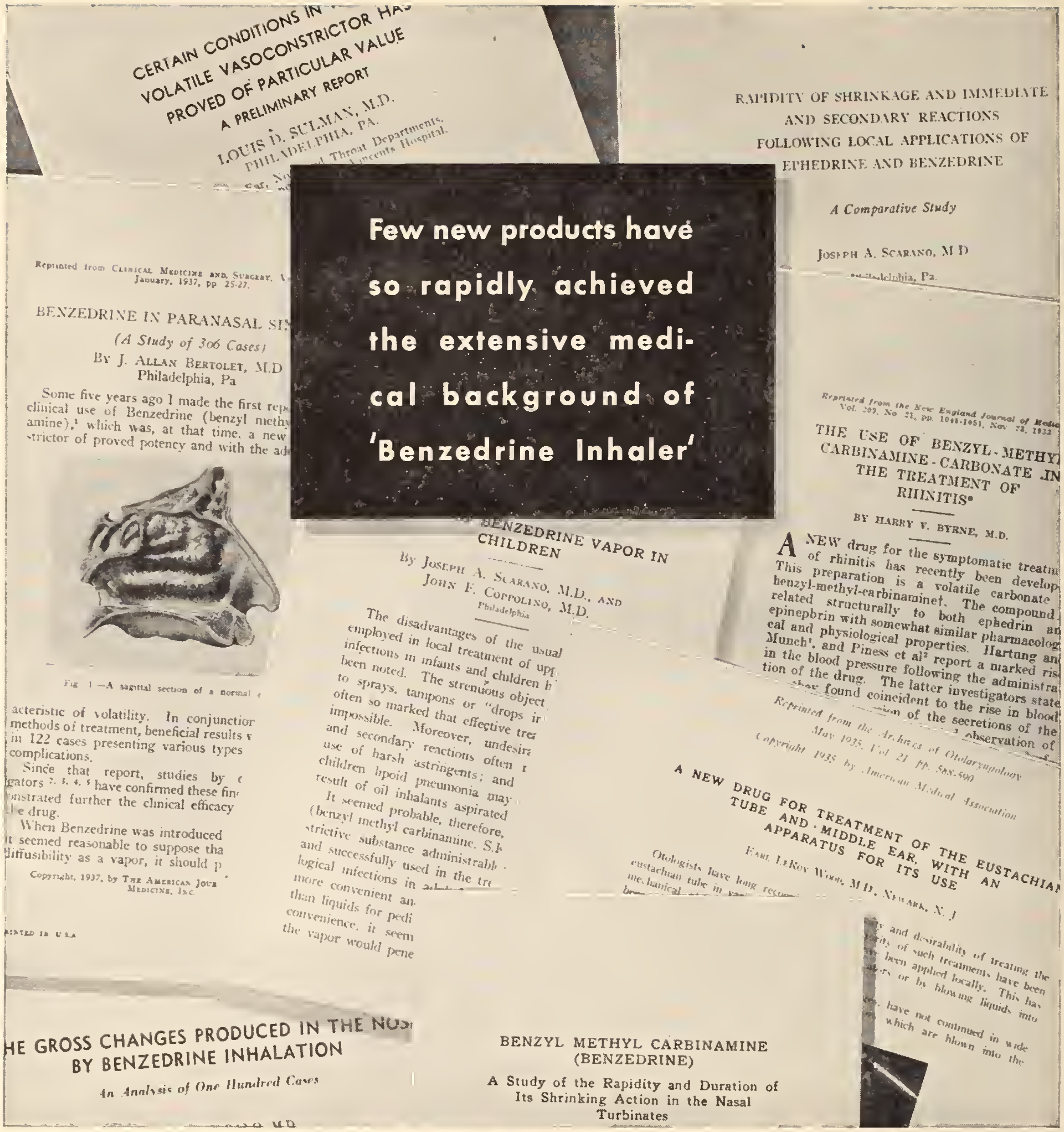

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RAPIDITY OF SHRINKAGE AND IMMEDIATE
AND SECONDARY REACTIONS
FOLLOWING LOCAL APPLICATIONS OF
EPHEDRINE AND BENZEDRINE
A Comparative Study
JOSEPH A. SCARANO, M.D.
Philadelphia, Pa.

Reprinted from CLINICAL MEDICINE AND SURGERY,
January, 1937, pp. 25-27.

BENZEDRINE IN PARANASAL SI
(*A Study of 306 Cases*)
BY J. ALLAN BERTOLET, M.D.
Philadelphia, Pa

Some five years ago I made the first rep clinical use of Benzedrine (benzyl methy amine),[1] which was, at that time, a new strictor of proved potency and with the ad

Fig. 1.—A sagittal section of a normal

acteristic of volatility. In conjunctior methods of treatment, beneficial results in 122 cases presenting various types complications.

Since that report, studies by gators [2, 3, 4, 5] have confirmed these fin onstrated further the clinical efficacy e drug.

When Benzedrine was introduced it seemed reasonable to suppose tha diffusibility as a vapor, it should p

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BENZEDRINE VAPOR IN CHILDREN
By JOSEPH A. SCARANO, M.D., AND
JOHN F. COPPOLINO, M.D.
Philadelphia

The disadvantages of the usual employed in local treatment of upp infections in infants and children h been noted. The strenuous object to sprays, tampons or "drops ir often so marked that effective tre impossible. Moreover, undesir and secondary reactions often r use of harsh astringents; and children lipoid pneumonia may result of oil inhalants aspirated

It seemed probable, therefore, (benzyl methyl carbinamine, S.K strictive substance administrabl and successfully used in the tr logical infections in adu more convenient an than liquids for pedi convenience, it seem the vapor would pene

Reprinted from the New England Journal of Medicine
Vol. 209, No. 21, pp. 1048-1051, Nov. 23, 1933

THE USE OF BENZYL-METHYL CARBINAMINE-CARBONATE IN THE TREATMENT OF RHINITIS*
BY HARRY V. BYRNE, M.D.

A NEW drug for the symptomatic treatm of rhinitis has recently been develop This preparation is a volatile carbonate benzyl-methyl-carbinamine†. The compound related structurally to both ephedrin an epinephrin with somewhat similar pharmacolog cal and physiological properties. Hartung an Munch[1], and Piness et al[2] report a marked ris in the blood pressure following the administra tion of the drug. The latter investigators state they found coincident to the rise in blood of the secretions of the observation of

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A NEW DRUG FOR TREATMENT OF THE EUSTACHIAN TUBE AND MIDDLE EAR, WITH AN APPARATUS FOR ITS USE
EARL LEROY WOOD, M.D., NEWARK, N. J.

Otologists have long recog eustachian tube in mechanical

y and desirability of treating the ity of such treatments have been been applied locally. This has ers or by blowing liquids into

have not continued in wide which are blown into the

HE GROSS CHANGES PRODUCED IN THE NOS BY BENZEDRINE INHALATION
An Analysis of One Hundred Cases

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(BENZEDRINE)
A Study of the Rapidity and Duration of Its Shrinking Action in the Nasal Turbinates

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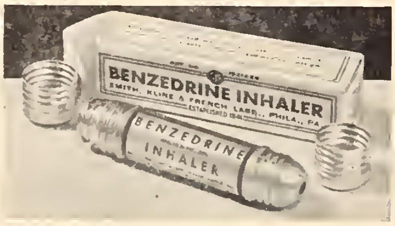

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●

BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

I. CLEANSING OPERATIONS

● As reference to a recent text on canning will disclose (1) the details of commercial canning procedures will vary from product to product. There are, however, certain basic operations which are included in practically all canning procedures. In the belief that they may prove of interest, it is our intention to describe in broad detail the nature and purposes of these essential operations.

One of the first and most important steps in commercial canning is the thorough cleansing of the raw food material received at the cannery. The purpose of such an operation is, of course, immediately evident, namely, to remove soil, dirt or other inedible substances which may be present. However, cleaning also serves to reduce substantially the load of spoilage bacteria with which Nature usually endows raw foods.

Commercially, cleansing is effected in a variety of ways. In general, however, water washers specifically designed for the various types of products are used. In these machines, the raw food material is subjected to high-pressure sprays or strong flowing streams of potable water while passing along a moving belt or while being tumbled by agitating or revolving screens. Sometimes a "flotation" type of washer is also used to remove chaff or similar material. With certain products, water washing is preceded by a "dry" cleaning treatment in which adhering soil and dirt is mechanically removed from the food by revolving or agitating screens, or by strong air-blasts.

Also, in certain canning procedures, operations whose basic functions are not primarily to clean the raw material may also exert a cleansing effect. Thus, the "blanch" or scalding treatment accorded many products serves to clean the food, as does the water spray sometimes applied to foods after the blanch.

Modern canners know the necessity of thorough cleansing of the raw materials they use. They appreciate that thorough cleaning and removal of extraneous material decreases the load of spoilage organisms which must be destroyed by the heat processes to which all canned foods are subjected. They also appreciate the necessity of maintaining strict plant and equipment sanitation to destroy spoilage bacteria which may be carried in by raw foods.

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AMERICAN CAN COMPANY

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(1) 1937 Appertizing or The Art of Canning,
A. W. Bitting,
The Trade Pressroom, San Francisco.

(2) Preventive Medicine and Hygiene,
M. J. Rosenau,
Appleton-Century Co., New York.

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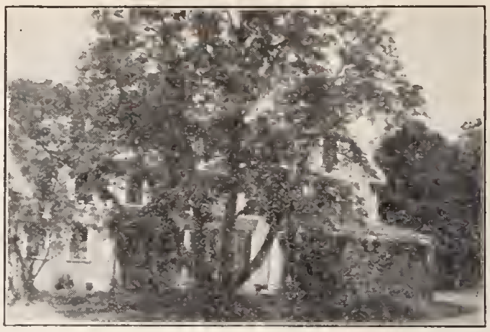

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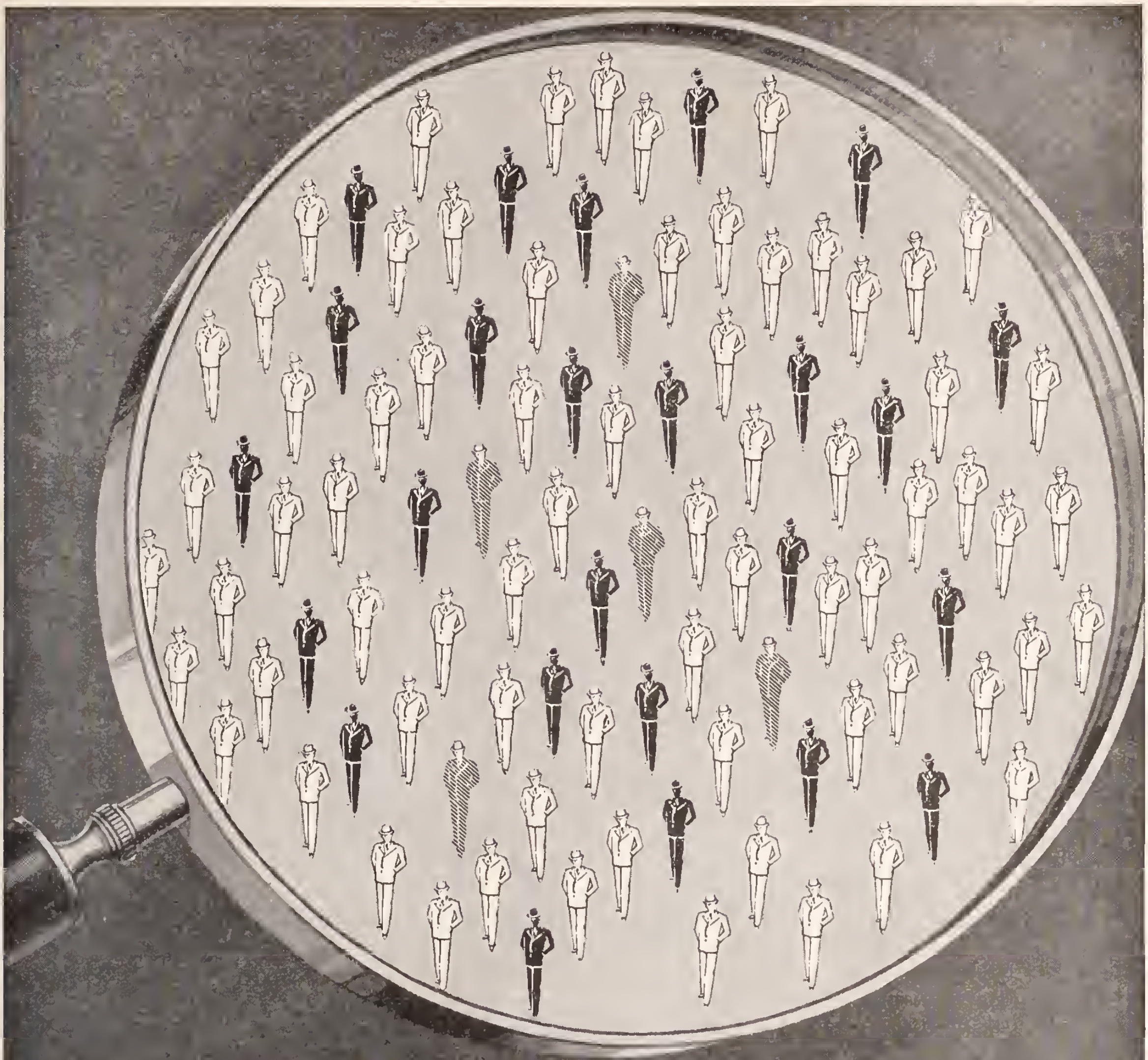

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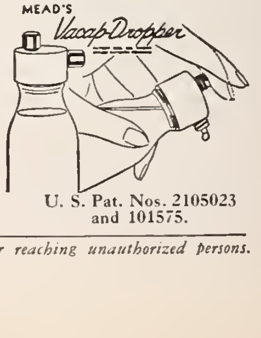

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Maine Medical Journal

The Official Organ of

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Vol. XXIX *Portland, Maine, March, 1938* *No. 3*

*Obstetrics in Scandinavia**

By Virginia C. Hamilton, M. D.,

South Harpswell, Maine

It is well known that maternal and infant mortality are lower in Norway and Sweden than anywhere else in the world. In Oslo this was 1.5 per 1000 in 1936; in the largest maternity hospital in Stockholm, 2.4 per 1000 live births. Puerperal mortality in the U. S. A. registration area is 6 per 1000. Before I visited these countries I had heard it stated that these favorable figures were due to the high standard of training for midwives and the system of district midwives working under and in close coöperation with the district physicians. Undoubtedly this is one of the causes and an important one, but there are others which must also be taken into consideration.

Practically every parturient woman in Scandinavia is attended by a midwife. This applies to those who have engaged a physician as well as to the great majority who have not. In the former case the midwife calls the physician when the time for delivery is at hand; in the latter, if the labor is normal, she delivers the woman herself (as she is thoroughly qualified to do). If any abnormality presents itself or if she is in doubt, the midwife calls the physician in *any* case. No operative deliveries are performed by midwives. They are, however, extremely skilful in normal deliveries and thoroughly familiar with the progress of labor and the early signs of complications arising in it, so that they know when to call for obstetrical aid. Their grounding in the theory of obstetrics and asepsis, a wide practical experience, and a skilled technique are acquired through a minimum of two years (to be increased to three next year) of hospital training. The requirements for entrance on such a course correspond to a high school education in America, and the examination for licensing is a strict one. Midwives are required to attend post-graduate classes every year. Midwifery is a proud and respected profession recruited from the same class of women as those who become registered nurses. The physicians are universally in favor of the system because it saves them much time and annoyance, while assuring responsible care.

In Stockholm 98% of all births take place in maternity hospitals—the majority in the two great public ones, Allmänua and Södrabarnbordhuset, the others in private, obstetrical clinics—*none in general hospitals.* In the country nearly all births are in the home, only abnormalities being taken to the general hospitals. In Oslo an intermediate condition prevails. The number of births taking place in special maternity clinics is increasing, but there are, as yet, not nearly enough beds to care for all; so that home delivery of normal cases is still quite prevalent. This is true of Copenhagen also.

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* Read at the Brunswick Medical Club, January 4, 1938.

The rarity of puerperal infection (1 death in Oslo in 3,220 births; 2 in Stockholm in 2,543 births) may well be attributed to the fact that the woman in normal labor *is attended by persons who have no part in the care of medical or surgical patients and that she lies in a place which has no connection whatever with the hospitals where such patients are lodged.* These two prerequisites have been emphasized repeatedly by DeLee.

The obstetrical routine of the woman in labor differs greatly from that in America. The difference is interesting but I think has not very great practical significance for us because of a difference in typical anatomy in the two countries. That is to say, I believe the secret of the great difference lies in the extreme rarity of contracted pelves in Scandinavia. This in turn is dependent on the practical absence of rickets there, as well as on the broader body-build of the race.

In Norway and Sweden practically no analgesia is used except a little ether at the end of the second stage and, of course, the usual ether anæsthesia for forceps or other operative delivery. Our barbiturates and opiates are simply not employed. The reasons given are fear for the baby's life and vitality and need for the mother's coöperation in bearing down. On the other hand, pituitrin (in minimal doses, it is true) is very commonly used in the second stage if the pains are not fully satisfactory. The whole trend is to make labor shorter, though perhaps more painful; while in America we attempt to render it painless (or at least to prevent memory of the pain) although realizing that it may be somewhat prolonged by the analgesics used and that the incidence of forceps delivery is increased.

Operative delivery is comparatively very rare in Scandinavia. (3 Cæsareans and 68 forceps in 2,543 births in Stockholm, of which 1,317 were primiparous.) I believe that this and the successful use of pituitrin are both dependent on the universality of ample pelvic dimensions more than on the attitude of physicians toward operative delivery or their skill in the use of the oxytocic. It is true that we, in America, may be said to have gone to extremes in operative delivery and in the use of analgesics. It would certainly be well if we would individualize more and consider our indications more closely. Also we may have gotten too dogmatic in our judgment against pituitrin before the third stage because of disastrous experience in our early use of it. Here again we might cautiously revise our ideas a little. *But I am sure that if we should adopt the Scandinavian technique in toto, out of enthusiasm for their statistical results, the effects would be disastrous.* Much unnecessary suffering would occur if we should reject our whole system of analgesia (even if it were possible to persuade American women to do without it) and numerous calamities would certainly occur in difficultly estimated borderline contracted pelves if pituitrin were more generally used instead of allowing time for moulding. The question of analgesics is being much agitated in Scandinavia at the present time. I read an article in one of their lay women's magazines by a woman physician who had been sent to America to study our use of them. She exaggerated the horrors and dangers greatly, I think, in her efforts to quiet the Swedish women's demands for these aids, but there was some truth in what she said. I think our women have come to have an exaggerated idea of the agony of childbirth and an exaggerated demand for complete analgesia, which, especially in our larger centres, has been too much indulged—to the disadvantage of the child and to the extreme inconvenience of the physician. We all know how much easier it is to work with a woman who can and will coöperate than with one who is completely "out" and thrashing wildly about in an amytal delirium. Also we know the difficulty of resuscitating a baby who comes from a deeply narcotized mother. There, as in everything else, the "middle way" is best and Scandinavia and

America might do well to average their use of analgesics and "split the difference."

In the matter of prenatal care I was surprised to find how sketchy Scandinavia is. The urine is examined a few times in the later months of pregnancy and if albumin is found a low protein, salt-poor diet prescribed. If œdema occurs the blood pressure is taken and if it is high the patient is put to bed. The whole thing is rather casual and anything like our elaborate system of preventive advice is just beginning to be thought of. Except for positive indications, no change is made in the diet—and the ordinary Scandinavian diet, especially in Sweden, is very excessive (according to our ideas) in protein and salt. Toxemias are fairly infrequent and this leads to the thought that perhaps we have been a little overly-zealous in our curtailment of protein and salt in uncomplicated cases. The very high average consumption of butter, eggs, fish and cheese no doubt contributes to the absence of rickets which I mentioned above as a contributing cause to the good body build and consequent lack of obstetrical complications. No emphasis at all is placed on water intake in prenatal care. The average consumption in Sweden and Denmark is very low, in Norway more comparable to America. This difference is to a large extent compensated by the difference in average beer consumption in the two countries. Fruits and vegetables are not stressed in Sweden and Denmark, but play a much larger role in the Norwegian diet.

In Norway an interesting work is going on—begun in 1924. There are now 14 thriving "Mother Hygiene Stations," which combine birth control with prenatal care and lessons in baby care in a most happy way. The idea is stressed that birth control is used for child-spacing and not for complete prevention of children. The stations are partially subsidized from municipal funds, partly from insurance funds (the universal worker's health insurance applies to expenses connected with childbirth). This money is applied to the salaries of the physicians connected with the work. The actual office expenses are defrayed from the sale of contraceptives and of layettes and baby supplies. This is an idea which could well be adopted in other countries—even America.

* * *

*Urological Complications of Fracture of the Male Pelvis**

REPORT OF FIVE CASES

By Clinton N. Peters, M. D., F. A. C. S.,

Chief of Urological Service, Maine General Hospital, Portland, Maine

The increasing incident of crushing injuries in our present-day existence of high speed transportation brings to the attention of the profession with greater intensity the growing frequency of fracture of the pelvis. While *per se* this is purely an orthopedic problem, complications involving the urological tract are so frequent, and results from their improper surgical care or failure to recognize them in the complicated picture presented at the time of injury are so grave, that I feel a word on the subject of their proper handling may be acceptable at this time.

In the male, the pelvic bones form, under ordinary circumstances, adequate protection for the soft parts of the urological tract, namely: the bladder, prostate, urethra, and deep portions of the corpora and the bulb of the penis. In the female from the urological viewpoint only the bladder is of importance. As rupture of this organ is usually readily recognized and offers no surgical complications except suprapubic drainage, and drainage of the peritoneal cavity, for the purpose of this paper, only the male will be considered.

Anatomically the strongest portion of the pelvis is the posterior portion with its heavy bones of the sacrum bound together solidly with ligaments to the ilia on either side. Extending from these and completing the bony cradle from below we have the ischii and the rami of the pubic bones fused none too strongly at the symphysis pubis, and protecting the softer tissues, extremely rich in blood supply and very vital to the body functions.

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* Presented at conference Maine Medical Association at Belgrade Lakes, June, 1937.

Given a severe crushing injury what inevitably results, providing the force is sufficient? The posterior portion of the pelvis withstands the crushing with fair success and the various ligaments of tough fibrous tissue tend to prevent jagged and sharp bony pieces from injuring the posterior contents of the pelvis, which in themselves being very loosely attached, readily aid the process. Thus we may assume that the intestinal tract escapes the onslaught. Not so the anterior part of this bony cradle with its important organs. From below, the rami of the ischium are bridged with the fibrous triangular ligament through which the urethra and penile bulb pass. Anteriorly they fuse with the rami of the pubis into the symphysis. Any crushing blow must of necessity involve somewhat the femurs and the brunt of the force is usually applied at about the level of the iliac fossæ. The result is inevitable. The rami of the pelvis break laterally or below the symphysis, and the jagged ends are pushed inwardly, tearing or puncturing, and at times completely severing the urethra and its surrounding soft structures. If the bladder is distended at the time of accident, rupture of this organ is an added complication.

Given a case of this type what is the procedure of choice?

First establish by X-ray the condition of the bony pelvis.

Second attempt to pass a catheter. Resistance to its passage with free bleeding is *prima facia* evidence of urethral injury.

Third, should the catheter pass and bloody urine be obtained, bladder injury is very strongly suspected.

Given these findings let me impress that watchful waiting is far more hazardous than proper surgical exploration. The cases should be approached from a urological viewpoint at once, and the orthopedic side be left for a later procedure. Suprapubic investigation of the bladder will establish the condition of this organ. If ruptured into the peritoneal cavity, suitable drainage must be instituted.

Many of the cases showing no bladder injury will have the urethra and bulb so nearly severed that the resulting hemorrhage into the bony pelvis, prevented from extending downward or laterally by the fibrous structures, will, at times, literally raise the bladder out of the pelvic cavity almost above the pelvic brim. In such cases simple bladder drainage is not sufficient, as an area of mascerated urethral tissue between the triangular ligament and the prostate gland will result in complete obliteration of the canal as in a case so treated which was recently brought to my attention.

Replacement of the bladder by removal of the underlying blood clots, retrograde catheterization to open the canal, perineal drainage with fixation of the bladder back in its normal position by traction with a Pilcher bag, or, in emergency with the large sponge sewed to a catheter and anchored to the thigh or fixed with a Hamar wire anchor as is used for suprapubic prostatectomy, with control of hemorrhage by packing, is a matter of short duration by the experienced urologist. Drainage of the bladder suprapubically will prevent sepsis, and careful removal of perineal packing and prevesical packing will eliminate future hemorrhage. A catheter of suitable calibre placed in the urethra, and pulled slightly out of the perineal opening, will establish the patency of this organ anteriorly. If we leave a traction suture in the Pilcher bag or to the catheter with the sponge attached, and bring it out the suprapubic wound, at the proper period of convalescence, we can sew the catheter in the anterior urethra to the perineal end of the Pilcher bag, and pull them gently thru the re-established urethra, and into the bladder for catheter drainage while the suprapubic wound heals. Scar tissue in the canal requires periodic dilatation like any stricture.

Following is a very brief account of five cases so treated by me. I have been told of three others, two of which died without surgery, and one in which the bladder was not replaced by traction and the urethra completely obliterated by scar tissue. This case had suprapubic drainage for a long time followed by extensive surgery with doubtful results. Proper procedure at the time of accident would have eliminated this grief.

Case I. Man, aged twenty, a conductor, caught between two street cars. Pelvic fracture with torn urethra. Was seen with foul suprapubic wound, obliterated urethra and prevesical sepsis after surgery. Perineal section, and suprapubic exploration, was instituted. The urethra was re-established and result except for urethral stricture excellent. Is active and working today.

Case II. Boy, aged fourteen, thrown from horse. Pelvic fracture, intraperitoneal rupture of bladder. Suprapubic, peritoneal, and perineal drainage. Result excellent.

Case III. Boy, twelve, run over by father's truck. Pelvic fracture with ruptured urethra. Suprapubic drainage with retrograde catheterization. Result excellent.

Case IV. Laborer, thirty years old, crushed between bucket of steam shovel and large boulder. Pelvic fracture and complete rupture of urethra and bulb. Bladder and prostate lifted by blood clot completely out of pelvis. Suprapubic drainage, removal of blood clot, bladder replaced and held by traction. Perineal drainage and packs with retrograde establishment of urethra. Result excellent.

Case V. Man, thirty-two, was crushed when horse he was riding fell on him. Pelvic fracture with complete rupture of urethra and bulb. Was consulting surgeon at time of operation. Suprapubic drainage, retrograde catheterization, perineal drainage and packing for hemorrhage. Result excellent.

In conclusion: I. Severe pelvic fracture in the male is almost sure to result in injury to the urogenital tract.

II. Prompt surgical intervention is less dangerous than watchful waiting.

III. The suprapubic approach is the procedure of choice.

IV. Re-establishment of the urethral canal with traction to hold the bladder well down in the pelvis is necessary when the urethra is completely severed.

V. Perineal drainage will do much to prevent stormy convalescence from pelvic infection.

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*Some Causes of Frequency and Urgency With No Urethral Obstruction**

By R. L. Huntress, M. D., Portland, Maine,

Urologist to O. P., Maine General Hospital

The first of these conditions is peculiar to women; chronic granular non-specific urethritis. The cause of this condition is not known, but occurs most frequently in women past the menopause. The chief symptom is frequency; there may be a desire to urinate every few minutes throughout the day. The desire becomes less on reclining or during bed rest. There is usually some dysuria, which is probably caused by the associated trigonitis. The urine is clear and absolutely normal, therefore these patients are often labeled neurotics. The diagnosis can only be made by examination, the urethral walls may be slightly thickened and the mucous membrane is covered by granulations. Inspection of the trigone often shows the same condition.

The treatment is simple, dilatation of the urethra above 32 F. and instillation of 10% Argyrol. I have often found Theelin in oil helped. This treatment relieves but may have to be repeated at intervals. I believe this condition analogous to the changes seen in the vagina in senile vaginitis. It does not seem to be due to infection, but old chronic infection may of course predispose.

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* Read before the Portland Medical Club, October 5, 1937.

The next condition occurs more often in women but has been reported in men. This condition has many names: 1. Elusive ulcer of Hunner (who first reported it); 2. localized submucous fibrosis; 3. panmural cystitis. Patients with this condition have to urinate every few minutes and suffer severe pain in the bladder if unable to void at once. The frequency is caused by the pain coincident with stretching of the ulcer. These patients have the frequency at all times in contradistinction to the previous mentioned condition where reclining relieves. Hunner thought focal infection the cause, but it is not generally believed.

These cases also have a normal urine and have often been called neurotics. A presumptive diagnosis may be easily made. The patient complains of great frequency, the urine is absolutely normal. instillation of an ounce of fluid into the bladder causes great pain and desire to void. The correct diagnosis is made by cystoscopy under gas or spinal anesthesia. As the bladder is distended bleeding ulcers are seen in the submucous layer of the bladder. Healed ulcers are noticed as stellate scars. Treatment relieves temporarily, but as can be seen by the number of types of treatment none can be perfect or all would use it. Over distention of the bladder under anesthesia works fairly well, some also electro coagulate the ulcers. Injections of absolute alcohol into the ulcers is advised by some. Some regard this condition as analogous to Lupus Erythematosus and use gold sodium thio-sulfate. Theelin in oil may be helpful. Total cystectomy has been done in the past but is not advised.

Cystitis due to various organisms is the most common cause of frequency and urgency. The most serious cause is T. B., which should always be diagnosed early if life is to be prolonged. T. B. of the urinary tract starts in the kidney, then descends to the bladder, causing ulcers, which make frequent urination imperative. In any patient, the young in particular, with frequency. urgency, pus in the urine and hematuria, T. B. should be suspected. If the urine culture is negative T. B. must be excluded. The diagnosis is made by pyelograms, urine smears, or G. Pig inoculation. It should be remembered that the treatment is medical as well as surgical. Instillations of 1% Phenol solution into the bladder after removal of the infected kidney often helps to heal the ulcers of the bladder.

Any organism may cause infection of the urinary tract and cystitis, but the colon group are the most frequent offenders. It is best to catheterize the ureters in most all cases and make cultures of the urine. At the present time it is best to treat all bacillary and streptococcus fæcalis infections of acid urine with Mandelic Acid. The urine should be brought to a P. H. of 5 or 5.5 with Ammonium Chloride. Mandelic Acid will then make most all urines sterile in five days if there are not stones, diverticula or obstruction, and may in any case in spite of complications.

Mandelic Acid should never be used if renal insufficiency exists because it often injures the kidneys. A poor kidney may not come back.

It is useless to treat an alkaline infection (caused by Proteus ammoniæ) with Mandelic Acid. The urine cannot be made acid because Proteus splits urea to ammonia so rapidly. Fortunately Sulphanildanide works better in an alkaline urine and should be used in these cases with the usual caution.

I have also found Neoarsphenamine .15 gms. intravenously very efficient in coccic infections of the urine, particularly staphylococcic infections.

To attain success in treatment of the urinary tract a positive diagnosis must first be made and the complete condition known. Exact treatment gives excellent results, but haphazard therapy without investigation is usually valueless.

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*Pyuria***

E. W. Gehring, M. D., Portland, Maine

Few subjects in medical practice have been as intensively studied and as ably reported recently as that of infections of the urinary tract, and probably the most definite finding has been that we have no uniformly efficient and reliable urinary antiseptic, much less germicide.

By antiseptic is meant an agent that will retard the development or prevent the growth of micro-organisms. A germicide is an agent that will kill such organisms.

Van Alstine states the commonly accepted view with reference to present remedies when he says, "I expect little and am usually not disappointed." Reimann, in speaking of acute pyelonephritis, states that, treated or untreated, 50 per cent. recover completely, 30 per cent. recur and 20 per cent. become chronic.

A few other deductions are of especial interest:

We must revise our ideas of the structures most commonly involved. I asked a capable general practitioner what percentage of his cases of urinary infection were cystitis. He replied, "About 50 per cent." This commonly accepted conclusion probably is based on the frequency of dysuria as a symptom. Walther and Willoughby in a careful study of 1,500 cases found the following percentages of incidence:

Pyelonephritis,	43
Urethritis,	32
Prostatitis,	24
Cystitis,	1

Some recent texts omit cystitis as a separate entity; some others devote only a paragraph or two to its consideration.

In from 75 to 80 per cent. of these cases, the colon group is the exciting factor, and most of the remainder result from various other nonspecific organisms.

About one pyuria out of every four will be due to bacteria other than colon and here the treatment (as given for colon) will have to be modified.

I shall not attempt to discuss here the necessity for a careful history and for a general examination of all patients with pyuria. My purpose is to consider the relative values and the methods of employment of some of the agents used in direct therapy.

Water is the most valuable agent at our command, and during the earlier stages of infection, when discomfort is often intense, a large fluid intake is often all that is necessary to secure at least the comfort of the patient. The actual amount to be prescribed will depend upon various factors that require individualization. A common instruction is "a glass of water every hour when awake."

Among alkalis, sodium citrate (U. S. P.) is the drug of common choice, though sodium bicarbonate (U. S. P.) and many related salts are used singly or in combination. Alkalinization is particularly desirable in the early stages of infection, especially if the urine is highly acid and dysuria is present. It should be remembered that these alkaline salts are not antiseptic. Miller especially recommends this therapy in cystitis.

Frequent changes in the reaction of the urine sometimes exert a beneficial influence. These salts are given in sufficient amounts to render the urine aklaline for a few days. Then the reaction is changed to acid for a corresponding number of days by the use of acid sodium phosphate or ammonium chloride (or nitrate). These intervals are alternated every five to seven days. For the acute stage of pyelonephritis, McCann recommends changing the reaction every seven to ten days.

Methenamine was introduced originally as a patent medicine under the name of urotropin. Later it was included in the Pharmacopœia under the name hexamethylenamine. In the U. S. P., it was given the name methenamine, for while the previous title was more descriptive chemically, it was too unwieldly for prescription purposes. It is a colorless crystalline salt, freely soluble in

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** Excerpts from "Therapy" by D. W. Bethea, *International Medical Digest*, August, 1934, Medical Review Conference, June 22, 1937.

water or in the form of 5- or 7½-grain tablets to be dissolved before administration. It is not recommended that it be prescribed as powders, as they lose weight when exposed to air. This same result takes place in the compressed tablets, but so slowly as to be almost negligible.

The therapeutic action of this drug depends on the liberation of formaldehyde, which, if in sufficient concentration, is an active germicide and in even moderate concentration has antiseptic value. This takes place *only in an acid medium.* Solis-Cohen and Githens have emphasized the fact that methenamine *as such* has no antiseptic value. As Sollman states, it has no antiseptic, irritant or toxic effect. As the gastric content usually is acid, a certain amount of the drug, probably from ⅙ to ⅓, is decomposed in the stomach. It is rapidly absorbed from the alimentary tract, and may be demonstrated in the urine in from 11 to 15 minutes after it has been taken by mouth. A large part of the drug is excreted unchanged. *It must be taken on an empty stomach.*

Vermooten and Berry have demonstrated that for formaldehyde to appear in the urine in sufficient concentration to have antiseptic value, the average dose of methenamine must be over 0.5 gm. (7½ grains) three times a day and that even here the urine must be distinctly acid and the fluid intake definitely restricted.

The therapeutic value of methenamine has been overestimated, and it has been recommended as more or less specific for a large percentage of human ills, including diseases of the alimentary tract such as typhoid, diseases of the gall bladder and of the central nervous system. It probably is not a diuretic, though this has been disputed. It has no remedial action *except in the urinary tract,* and then only as it liberates formaldehyde in sufficient amounts.

The consensus of opinion is that it is the most reliable *urinary* antiseptic known at present. Sollmann states that it is the most efficient, *if the urine is acid.* Davis and Sharpe found methenamine of fairly uniform value for colon bacilli and staphylococci. Folsom relies upon it almost entirely for urinary antisepsis. Vermooten and Berry place it in the first rank and feel with many others that its efficiency depends upon a low pH*. Solis-Cohen and Githens class methenamine as among the most effective agents and state that its efficiency is highest in the urinary bladder and urethra, less in the renal pelves. This seems reasonable, as the secretion in Bowman's capsules is alkaline and therefore no formaldehyde is released there. This chemical change takes place progressively as the urine passes through the renal pelves down the ureters and continues into the bladder.

It has been noted that an acid urine is essential if methenamine is to exert a therapeutic influence; it is, therefore, necessary that the diet be arranged accordingly. Particularly undesirable are the acid fruit juices, as in the body chemistry they tend to the formation of alkaline salts. Of course such drugs as sodium citrate and bicarbonate must not be used. Among the agents that are employed to render the urine actively acid are sodium biphosphate (acid sodium phosphate), ammonium chloride and ammonium nitrate. Others, such as the salicylates and benzoates, are used less frequently for this purpose. Miller recommends acid sodium phosphate in doses of from one to 2 gm. (15 to 30 grains) three times a day. Solis-Cohen and Githens advocate 20 grains of acid sodium phosphate one hour before each dose of methenamine. Walther and Willoughby prefer ammonium chloride.

I have seemed to find symptomatic relief, and some curative, value from the employment of the salicylates during these periods of acid urine. Acetylsalicylic acid particularly lends itself to symptomatic relief, when pain is a factor. Methenamine may be administered at the same time.

Another consideration that is being advocated is the restriction of the fluid intake during the time of the administration of any urinary antiseptic. This seems quite reasonable, when one stops to consider that the efficiency of any of these drugs depends entirely upon the *percentage of concentration* in the urine.

Methenamine is not without some unfavorable effects. It may cause marked dysuria. This, however, is promptly relieved by the administration of alkalis and large amounts of water. Hematuria is not infrequent, though this seldom develops until after fairly large doses have been administered for a number of days. It disappears, when the drug is discontinued. It should be remembered that these unfavorable effects are not from methenamine as such, but result from its chemical decomposition. The hematuria is almost entirely from the bladder.

The azo dyes have been studied extensively and some of these products, particularly pyridium and serenium, have been used largely in the treatment of urinary infections.

Pyridium, the first of these to be investigated intensively, is a proprietary remedy, marketed in the form of pills containing 0.1 gm. (1½ grains). The average dose is two pills three times a day. It colors the urine, and the patient should be advised of this, else it may cause unnecessary alarm. It is employed commonly in doses of 0.2 gm. (3 grains) three times a day for ten days, this being followed by a period of rest. The two principal disadvantages of pyridium are its expense and the frequency with which it causes gastric disturbances.

Serenium is also a proprietary remedy and is employed in practically the same way and for the same purposes as pyridium. It is on the market in the form of coated tablets containing 0.1 gm. (1½ grains). The average dose is one to two tablets two to three times a day. It colors the urine red if that fluid is acid. Bastedo states that it is practically non-toxic and that it acts best in an acid urine. The status of these agents in therapy has not been established finally.

Acriflavine is recommended by Walther and Willoughby for selected cases. Davis and Sharpe class *it* and methenamine as our two most reliable agents, especially for colon bacilli and staphylococci. They use it in doses of 0.2 gm. (3 grains) administered in capsules.

Hexylresorcinol is on the market as an oil solution under the trade name of caprokol. It is used rather largely by some in the treatment of urinary infections. The principal drawbacks are that it is expensive and that it tends to cause gastric disturbances.

Ketogenic Diet. This is being strongly advocated in the treatment of urinary infections as well as for many other pathologic conditions. Van Alstine states that it is valuable for the colon group infections when the pH is low. Reimann feels that the plan must be carried out 100 per cent. and states that efficiency of 90 per cent. in this particular will not give 90 per cent. favorable results. It has been stated that the value of this scheme depends upon the development of beta-oxybutyric acid. Needless to say, this plan would be advisable only for selected cases and the patient should be carefully observed for the development of symptoms of acidosis.

In this connection it should be recalled that diabetics, singularly, are free from G. U. infections, due to the presence in their urines of certain acid products of metabolism rendering the pH low. Of these, beta-oxybutyric acid has the highest bacteriostatic value. Since this acid is metabolized by the bodies of diabetics, it cannot be administered orally and is not found in the urines of non-diabetics.

These observations led directly to the discovery of mandelic acid, an organic acid of sufficient bacteriostatic action to be of practical value in G. U. infections. It is correct, perhaps, to say that, *in selected cases,* it has supplanted the repulsive, expensive and unphysiologic ketongenic diet whose value depends on the development of beta-oxybutyric acid. Abbott's Syrup Amdelate is most effective in colon infections, a trifle less so against the strepto and staphylococcus, not at all so against the tubercle bacillus or the bacillus proteus.

It is contraindicated in nephritis and is of no value in specific urethritis.

* Statement concerning pH follows:

pH†

For convenience, the symbol pH has been adopted for hydrogen ion concentration, and in order to avoid fractions or decimals, the degree of acidity or alkalinity is expressed as the negative logarithm. For instance, the hydrogen ion concentration of water, which contains to the liter one ten-millionth of a gram (000,00001 gm. or 10-7) of hydrogen ions, is expressed as pH-7.

In using this symbol, however, it is important to bear in mind two things. Since this figure represents a fraction, the larger the figure the smaller the amount of the substance it expresses; thus while pH-7 means neutrality, pH-6 actually means an increase in hydrogen ion concentration and therefore acidity, and pH-8 means decrease in hydrogen ions and therefore alkalinity. For this reason the terms "increased hydrogen ion concentration" and "decreased pH" are synonymous and are interchangeable. The other fact which may be confusing is that a decrease or increase of 1 in pH values means a tenfold change in reaction; thus pH-5 is ten times more acid than pH-6.

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† McLester, "Disorders of Metabolism," Page 84, *Oxford Monographs,* Vol. 1, Medical Review Conference, June 22, 1937.

The President's Page

To the Members of the Maine Medical Association:

I have been requested by our President, Dr. Wakefield, to furnish material for the President's Page in the March issue of our JOURNAL.

It is indeed a pleasure to have the opportunity of sending a message at this time to the members of our Society, and I sincerely hope that my remarks will be taken kindly and any errors will be generously overlooked.

I must necessarily refrain from discussing subjects referred to by Dr. Wakefield during the year, and I am very sure many more important messages will be forthcoming upon his arrival from the "Sunny South."

However, the question of attendance and lack of interest at County and State meetings is a subject that should never be exhausted. We all fully realize that year after year our Society is confronted with more and more difficult problems, too numerous to mention here, and that the burden of this bundle is carried on the shoulders of a few.

The older members having retired after years of active service are inclined to stay home or be merely visitors, and complacently resign themselves to the fact that their labor for the Society is ended. This is indeed unfortunate, and if we carefully analyze the situation, it must necessarily be a cause for sadness and regret.

Now what about the younger men of our profession? What are your problems? How do you see things?

Remember, you are looking through the eyes of youth and for that reason we are keenly interested in your viewpoint and solicit your coöperation.

Our difficulties will be yours in the near future, our gains and losses will also be yours. Believe it or not, you will be carrying the burden of our Society all too soon. Why not start now by attending your County and State meetings, express your ideas, become acquainted, enjoy the opportunities presented to you, and above all things, participate in the spirit of good fellowship which I sincerely hope will be present at all of our meetings in years to come.

WILLARD H. BUNKER, *President-Elect.*

Editorials

Further Cancer Educational Effort

Success in any undertaking depends on vigorous, well-directed and sustained effort. No finer example of accomplishment, through such effort, can be cited than the splendid work done by the Women's Field Army, Maine Division, of the American Society for Control of Cancer, so ably directed by Mrs. William Holt, of Portland, the State Commander. The things accomplished have been brought about only by continuous effort, many miles of travel to all parts of our far-flung State, personal sacrifice and the exercise of rare good judgment and determination to succeed.

As a direct result of the $1.00 membership campaign of 1937, a splendid bit of educational work done among the women of Maine, who contributed in all about $15,000.00 as a fund to be expended, through our State cancer clinics, in the diagnosis and treatment of needy patients who are unable to pay for such services.

This alone is a splendid tribute to cancer educational effort in general and to the Maine Women's Field Army in particular.

From the data furnished, in a recent letter sent to every physician in the State by the Chairman of the Women's Field Army, it is clear that a very definite need in the treatment of the unfortunate cancer patient is already being filled here in Maine. A fund has been established, needy patients are being treated in increasing numbers; a definite objective has been reached. Without the money raised by the Maine Women's Field Army the physicians of Maine would not have been able to give their indigent cancer patients proper treatment at all.

It now behooves every physician in the State to give his hearty coöperation and support to this effort as it goes into its second year.

So great has been the demand for free diagnosis and treatment that the funds will soon be exhausted unless a further determined effort is made to add to them.

The week of April 2 to 9, 1938, has been designated as the time for the second Field Army membership drive. At this time physicians will be asked to help out purely in the educational part of the program.

The Women's Field Army has presented you with the funds with which to treat your needy patients. You cannot do less than give their efforts the strong backing of your wholehearted support in order to show your gratitude for the splendid service they have rendered you and your patients.

The Women's Field Army

The Women's Field Army, which is the educational arm of the American Society for the Control of Cancer, is already actively engaged on its winter campaign culminating in a drive for enlistments in the Army to fight cancer at one dollar a year during the month of April. Although this drive represents the climax of the campaign, the Army carries on an active educational program throughout the year.

Physicians are frequently asked to lend their aid by speaking before groups of women —or men—on the recognition of early or suspicious signs of the disease. In this connection we suggest to our readers that the officers of the Women's Field Army have merited the full support of the medical profession in their sane, well-organized effort to bring within reach of the people of this State a knowledge of the early signs of cancer sufficient to enable them to recognize the possible significance of conditions which should bring them promptly to the consulting room of a reputable physician. The people need too the assurance from the physician that an encouraging and ever-increasing number of cases can be permanently cured if discovered in time.

At present far too many persons, on the discovery of an apparently trifling condition which suggests to them the possibility of cancer, conceal their suspicions until—if the trouble prove to be indeed malignant—all hope of permanent cure has passed.

Others are led to consult some irregular practitioner, attracted by his boast that he "never uses the knife." It is only an intelligent understanding of the nature and behavior of the disease that can protect people from acceptance of such misleading statements.

In each one of the forty-one State organizations of the Women's Field Army, the plan of campaign, as well as the expenditure of 70% of all monies collected, is carried on with the advice and under the direction of an Executive Committee, the nucleus of which is the Cancer Committee of the State Medical Society. Otherwise medical guidance is afforded by a group of physicians selected because of especial interest in the problems of cancer, from among the members of the State or County Medical Society.

The organization of the Army itself consists of a line of officers ranging from the State Commander down through regional Captains, community Lieutenants, and local Sergeants, to the soldiers in the field. The actual work of securing enlistments, of arranging for educational talks or exhibits, the distribution of literature, etc., is done under the immediate direction of the Sergeants.

At every step in which medical guidance has been needed the Army has turned to the organized profession for leadership. There is every reason, therefore, why the medical profession should lend its fullest support and all possible aid to this worthy endeavor to place the results of recent research in the hands of those who can most directly profit by the newer knowledge of cancer, thereby helping to lessen the wastage of useful lives through unnecessary deaths from cancer.

The Commander of the Women's Field Army in this State is Mrs. William Holt, Portland.

The Chairman of the Executive Committee is Edward H. Risley, M. D., Waterville.

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Women's Field Army

Advisory Board Chairmen of the Women's Field Army for the Control of Cancer

Members of the medical profession in all parts of Maine will lend their assistance to the program of the Women's Field Army in the forthcoming enlistment and educational campaign for the control of cancer. The goal of the Army for 1938 has been set at $25,000, and to date, under the direction of Mrs. William Holt of Portland, State Commander, 70 units have already been organized with an additional 30 in process of organization. Units organized represent about seven-eighths of the communities in the State.

It is the hope of the Women's Field Army to attain its objective this year, that of raising the full quota, in order that the work of providing treatment and diagnosis to needy cancer sufferers may be broadened throughout 1938. Approximately $15,000 was raised in 1937, and this amount limited somewhat the activities of the Army in meeting all demands. If so designated by the donors, all special gifts directed to the Dr. Joseph W. Scannell Memorial Fund may be retained by the Maine Division in full, it was announced by the State Commander.

The week of April 2 to 9 is the period set for the active conduct of the State campaign, while the entire month of April has been designated throughout the Nation as Cancer Control Month.

To date upwards of 100 physicians have accepted the chairmanship of local advisory boards and with representation in all 16 counties, as follows:

York County

Paul S. Hill, Jr., M. D., Saco; James H. MacDonald, M. D., Kennebunk; Gerald

Smith, M. D., Ogunquit; William T. Elliott, M. D., Berwick; Charles W. Kinghorn, M. D., Kittery; Stephen A. Cobb, M. D., Sanford; Arthur G. Wiley, M. D., Bar Mills; Samuel G. Sawyer, M. D., Cornish.

Cumberland County

John M. Bischoffberger, M. D., Bridgton and Naples; Henry W. Beck, M. D., Gray; Louis L. Hills, M. D., Westbrook; Robert C. Pletts, M. D., Brunswick; Ervin A. Center, M. D., Steep Falls; Langdon T. Thaxter, M. D., Portland; Robert B. Love, M. D., Gorham; Howard Sapiro, M. D., Scarboro; Howard Hamblen, M. D., Windham; Nessib S. Kupelian, M. D., New Gloucester; Nat B. T. Barker, M. D., Yarmouth; Harvey Howard, M. D., Freeport; John E. Gray, M. D., Cumberland.

Sagadahoc County

A. A. Stott, M. D., Bath.

Lincoln County

Stanley Lenfest, M. D., Waldoboro; Robert W. Belknap, M. D., Damariscotta; DeForest S. Day, M. D., Wiscasset; George A. Gregory, M. D., Boothbay Harbor; Abbott J. Fuller, M. D., Pemaquid.

Waldo County

Carl H. Stevens, M. D., Belfast; LeRoy H. Smith, M. D., Winterport.

Hancock County

R. V. N. Bliss, M. D., Bluehill; R. W. Foster, M. D., Bucksport; John G. Chadwick, M. D.; Alphonse Gerend, M. D., Stonington and Deer Isle; Pliny Allen, M. D., Bar Harbor; George Parcher, M. D., Ellsworth; Charles Sumner, M. D., Sullivan.

Washington County

W. A. Van Wart, M. D., Cherryfield; Clarence W. Milliken, M. D., Jonesport; Oscar F. Larson, M. D., Machias; John L. Murphy, M. D., Eastport; Willard H. Bunker, M. D., Calais.

Androscoggin County

George H. Rand, M. D., Livermore Falls; W. E. Viles, M. D., Turner; John Busch, M. D., Mechanic Falls; Lester P. Gerrish, M. D., Lisbon Falls; George B. O'Connell, M. D., Lewiston-Auburn.

Kennebec County

Frank B. Bull, M. D., Gardiner; Greenlief H. Lambert, M. D., Winthrop; A. W. Moore, M. D., Readfield; Virgil C. Totman, M. D., Oakland; W. W. Hendee, M. D., Vassalboro; A. A. Shaw, M. D., Clinton; Vincent T. Lathbury, M. D., Augusta; Ralph L. Reynolds, M. D., Waterville.

Oxford County

Hubert T. Fitch, M. D., Brownfield; William M. Monkhouse, M. D., Fryeburg; R. E. Hubbard, M. D., Waterford; Delbert M. Stewart, M. D., South Paris; Raymond R. Tibbetts, M. D., Bethel; Eugene M. McCarthy, M. D., Rumford; Charles W. Eastman, M. D., Canton.

Franklin County

George L. Pratt, M. D., Farmington; Maynard B. Colley, M. D., Wilton; John H. Moulton, M. D., Rangeley.

Somerset County

Maurice E. Lord, M. D., Skowhegan; Franklin P. Ball, M. D., Bingham; Merlon A. Webber, M. D., Pittsfield; Oscar R. Emerson, M. D., Newport; Percy E. Gilbert, M. D., Madison; Harry W. Smith, M. D., Norridgewock.

Piscataquis County

Albert M. Carde, M. D., Milo; E. D. Merrill, M. D., Dover-Foxcroft; Ralph H. Marsh, M. D., Guilford; Norman H. Nickerson, M. D., Greenville.

Penobscot County

Forrest B. Ames, M. D., Bangor; C. L. Madden, M. D., Old Town; Asa C. Adams, M. D., Orono; Wesley C. MacNamara, M. D., Lincoln; Henry E. Whalen, M. D., Dexter; Ernest T. Young, M. D., Millinocket; Ezra B. Skofield, M. D., Corinth; Fred L. Redman, M. D., Corinna.

AROOSTOOK COUNTY

Arthur T. Whitney, M. D., Houlton; Storer W. Boone, M. D., Presque Isle; Herrick C. Kimball, M. D., Fort Fairfield; Oscar Norrell, M. D., Caribou; H. H. Hammond, M. D., Van Buren; Clyde I. Swett, M. D., Island Falls; J. L. Albert, M. D., Fort Kent.

KNOX COUNTY

William A. Ellingwood, M. D., Rockland; Charles H. Jameson, M. D., Camden; Victor H. Shields, M. D., Vinalhaven.

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Maine Ragweed Survey

Preliminary Report of the Maine Ragweed Survey for 1937

The doctors of Maine who have coöperated in the 1937 survey of air-borne pollens in August and September are entitled to an early or preliminary report on the distribution of ragweed.

Receiving stations were established in representative areas of the entire state, the coast and interior, cities and farms, lakeside and forested mountains. Dr. Coombs for the Bureau of Health has coöperated actively and efficiently and has helped meet the necessary expense. Slides were exposed for twenty-four hours and changed every morning for a fifty-day period during the ragweed season, under an exact rule for conditions of exposure. After our collection and counting, slides have been submitted to the chief botanist of the Abbott Laboratories in Chicago, whose final tabulation of the State of Maine survey will later appear in current medical journals.

There is no state east of the Rocky Mountains and north of Florida where ragweed control or eradication could so well be carried out as in Maine, owing to its extensive pollen-free boundaries. The reputation of Maine as a healthful vacation state is at stake. The medical profession is directly concerned that there should be a properly and scientifically conducted determination of ragweed prevalence and variance in the different localities, before a public demand for its destruction could be wisely advised. Also, there should be a positive statement before the enthusiasm of any one resort should run away with the truth in advertising. We are anxious that the doctors of Maine should be prepared to lead the state to an efficient control of hayfever. This control must be statewide to be economical. The local taxpayer could well object to the use of funds in spasmodic, scattered local efforts, more or less nullified by adjacent exposures. It will pay the State of Maine to enhance its reputation. It will pay the doctors to inform and instruct in a campaign to prevent the pollution of the air by ragweed pollen.

The magnitude of the task in corrections and recounting will delay the tabulation of each station, but the general results so far evident are strikingly important. No point in Maine is absolutely free from atmospheric ragweed pollen, even if no local ragweed can be found growing, but very many coast resorts are relatively free from the constant ragweed pollution which produces the continued discomfort and suffering of hayfever. In the whole north country of forest and lake, ragweed becomes more and more negligible, until the center of the vast potato-raising area comes the nearest to freedom from ragweed of any receiving station in Maine. Where the land is tilled and cropped each year, there is little or no ragweed. The city backyard produces the most pollen per acre of area, while neglected and untilled soils and roadsides furnish the bulk for general distribution. We are still studying the effect of wind and upper air currents in carrying and in depositing the elusively floating ragweed pollen.

One marked finding was the time of highest pollen count: September 2, 3 and 4, with no exception of any station. There were earlier high counts in August at varying dates, which may be explained by weather or winds. The uniformity of the dates of the highest counts suggests the maturing of the pollen under similar climatic conditions, with the consequent freer escape of the granules.

We will not forestall the findings by naming or comparing individual stations, but after these are published, it will be of great interest to us in Maine to locate the causes of the current hayfever. In fact, we hope that emulation and even rivalry will occur between different points in the state in the freedom from atmospheric pollens. Publicity will thus be stimulated, and nothing else will be so likely to rouse the public from apathy. From these general deductions must the plan be built up for state eradication. It can be done without waste in money and effort.

We cannot close without noting the highly commendable work of the service clubs and women's guilds in this and nearby states, who have succeeded in a near-absolute destruction of ragweed growing in their localities and thereby have lessened in some part the total amount of the atmospheric load to be carried by the winds and to be distributed without warning.

Signed:

C. B. Sylvester, M. D.

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Graduate Education

Post-Graduate Medical Fellowships

The attention of the members of the Maine Medical Association is called to the Fellowships now available to members through the Bingham Associates. Courses in intensive instruction in Internal Medicine are given at the New England Medical Center in Boston during the months of October, November, January, March and May. These courses are limited to six physicians in each month. Courses in Pediatrics will be given each month from October through May, the course in a given month being limited to two men. Requirements consist of membership in good standing in the Maine Medical Association and satisfactory recommendations, preferably from the committee on Post-Graduate Education. There is a stipend paid of $250.00 per month. It is the desire of the committee that these fellowships be allocated as near as possible to men in the smaller communities, who may not have the opportunities for hospital association that are available in the larger places. The courses are largely clinical, consisting of daily medical conferences conducted by outstanding Boston physicians and teachers, case study in the various out-patient departments, ward rounds, study of ward cases with didactic lectures on various phases of medicine daily. The New England Medical Center have associated in their group a number of leading German physicians, and emphasize this element in their clinic. Applications may be obtained from the State Secretary, Dr. F. R. Carter, or by applying direct to the New England Medical Center in Boston.

Frederick T. Hill,
Chairman of Committee on
Graduate Education.

County News and Notes

Cumberland

Following a dinner at the Eastland Hotel on Friday, February 25th, Maxwell Finland, M. D., of the Boston City Hospital, addressed seventy-five members of the Cumberland County Medical Society on *The Treatment of Pneumonia.*

Henry Swift, M. D., newly elected President, presided.

The next meeting will be late in April, date and speaker to be announced.

HAROLD V. BICKMORE, *Secretary.*

Portland Medical Club

The regular monthly meeting was held at the Columbia Hotel, Tuesday evening, January 4th, at 8 P. M. Thirty-one members were present.

Dr. Thomas Foster and Dr. Thomas Tetreau were appointed to serve on a Committee on Outside Relations.

The paper of the evening was by Dr. Francis W. Hanlon, who chose for his subject, *The Relation Between Acute Visceral Infections and the Alarm Reaction.* Following the paper, the subject of the use of histamine in various conditions was discussed.

ALICE WHITTIER, *Secretary.*

The regular monthly meeting was held at the Columbia Hotel, Tuesday evening, February 1st, at 8.15 P. M. Twenty-three members and three guests were present.

Mr. M. W. Bair of H. P. Hood & Sons showed a film on Certified Milk.

Dr. Thomas Tetreau presented the paper of the evening and his subject was *Milk as a Factor Influencing the Infant Mortality Rate in Portland.* He concluded that milk was not a very great factor in the infant mortality rate in Portland at the present time. The meeting was a very interesting one and many entered into the discussion of the subjects suggested by the film and by the paper of the evening.

A committee consisting of Dr. Thomas Tetreau, Dr. Harold Everett and Dr. Alice Whittier was appointed to study the causes of infant mortality in Portland.

ALICE WHITTIER, *Secretary.*

Hancock

At the annual meeting of the Hancock County Medical Association held November 30, 1937, the following officers were elected:

President: Harold S. Babcock, Castine.

Vice-President: Charles E. Sumner, Sullivan.

Secretary-Treasurer: Pliny A. Allen, Bar Harbor.

Delegate to the 1938 Annual Session, Maine Medical Association: George A. Neal, Southwest Harbor. Alternate: R. W. Clarke, Ellsworth.

Censors: Edward Thegan, 3 years; Philip L. Gray, 2 years; Harold S. Babcock, 1 year.

PLINY A. ALLEN, *Secretary.*

Kennebec

A meeting of the Kennebec County Medical Association was held at the Sisters' Hospital in Waterville, Thursday, February 17, 1938.

Clinical program at 5 P. M.

(1) Axillary Tumor for Diagnosis, Ovid Pomerleau, M. D. Imperforate Anus, Ovid Pomerleau, M. D. Frozen Hands, Ovid Pomerleau, M. D.

(2) Cancer of Bladder (two cases), A. B. Allen, M. D.

(3) Ureterectomy, C. E. Towne, M. D.

(4) Thyroid Case, L. A. Guite, M. D.

(5) Fractured Hip complicated by Chronic Lymphatic Leukemia, E. W. Harlow, M. D.

Dinner: 6.30 P. M.

Followed by a business meeting and scientific session. Minutes of the last meeting were read and approved.

Applications of Edward T. Gary, M. D., Togus, Charles D. Cromwell, M. D., Fairfield, Joseph H. C. Michaud, M. D., Waterville, and Wilson H. McWethy, M. D., Augusta, were received and referred to the Board of Councillors.

The following amendment was proposed and laid on the table until the next meeting:

AMENDMENT TO CHAPTER 1, SECTION 1:

"Medical Officers of the United States Government medical services who are stationed in Kennebec County may become members on application without registration in Maine upon payment of dues."

A letter was read which was received from Mrs. Wm. Holt of Portland, State Commander of Women's Field Army, relative to radium and X-ray treatment of malignant cases.

The address of the evening was presented by Jacob J. Schloss, M. D., Instructor of Medicine at Tufts Medical College and a member of the staff at the Boston Dispensary. It was an unusually interesting paper on "Recent Developments in the Diagnosis and Treatment of Diseases of the Stomach." This was amplified by lantern slides. It was followed by a very interesting and instructive discussion.

There were 57 members and guests present.

FREDERICK R. CARTER, *Secretary.*

Penobscot

The regular monthly meeting of the Penobscot County Medical Association was held on Tuesday, January 18th, in Bangor.

In the morning, ward walks were made at the Eastern Maine General Hospital, with Dr. Champ Lyons, of the Massachusetts General Hospital, Boston, Mass.

A medical clinic was held in the afternoon at the Hospital, with Dr. Lyons directing the discussion.

Dinner at the Bangor House at 6.30 was followed by the business meeting. New members were elected as follows: Havilah E. Hinman, M. D., Orono, Maine, and J. J. Pearson, M. D., Old Town, Maine.

The paper of the evening was presented by Champ Lyons, M. D., of Boston. The subject was "Modern Methods in the Treatment of Pyogenic Infections." Presentation was based on clinical and laboratory work done by and under the direction of Dr. Lyons at the Massachusetts General Hospital, with special emphasis on the streptococci, modes of invasion and methods of treatment in the host invaded.

FORREST B. AMES, M. D., *Secretary*,
Penobscot County Medical Association.

New Members

Penobscot

D. Allan Craig, M. D., Bangor, Maine.
Havilah E. Hinman, M. D., Orono, Maine.
J. J. Pearson, M. D., Old Town, Maine.

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Coming Meetings

Connecticut State Medical Society, Hotel Griswold, Groton, June 1-2. Creighton Barker, M. D., 258 Church Street, New Haven, Secretary.

Rhode Island Medical Society, Providence, June 1-2. Guy W. Wells, M. D., Providence, Secretary.

American Medical Association, San Francisco, June 13-17. Olin West, M. D., 535 North Dearborn Street, Chicago, Secretary.

Maine Medical Association, The Malvern Hotel, Bar Harbor, June 26, 27, 28. Frederick R. Carter, M. D., 22 Arsenal Street, Portland, Secretary.

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Lively Interest in Physicians' Tour of America by De Luxe Special Trains Enroute to the A. M. A. Convention in San Francisco

According to latest reports reaching us, physicians and their families are evincing a very keen interest in the arrangements made by the American Express Travel Service with the coöperation of your society to see America en route to and returning from the San Francisco Convention. This early interest indicates the assured success of this important Convention.

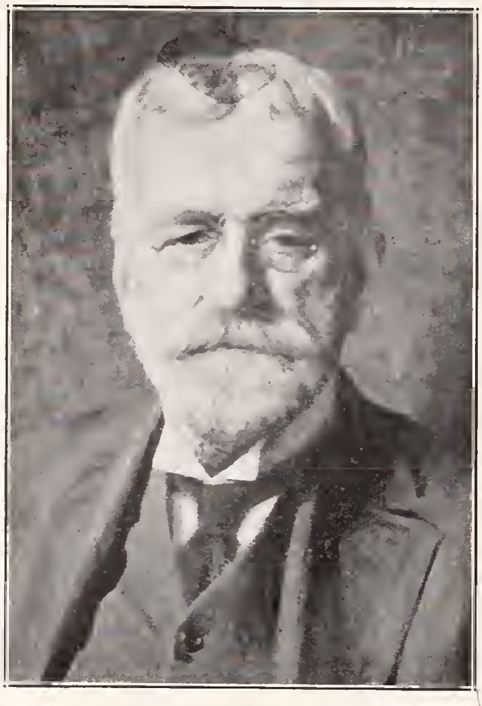
The "See America" movement by De Luxe Special Trains is endorsed by approximately twenty-five State Medical Societies. It presents an unprecedented opportunity for our members and their families to join with their colleagues from other States, and enjoy the facilities and service of De Luxe Special Trains, and at the same time visit the many scenic attractions of our western States.

Many physicians, completely immersed in their practices, have hesitated to take such an extended vacation heretofore but now the fact of the A. M. A. Convention and the attractiveness and economical features of this travel program has brought such a trip within the realm of desirable possibilities.

Picture the beauty and relaxation of such scenes as the Indian Detour in New Mexico, the Grand Canyon of Arizona, Los Angeles, and the beauties of southern California, Santa Catalina Island, the famous Columbia River Highway in Oregon, Seattle, Washington, Victoria, Vancouver, Lake Louise and Banff in the Canadian Rockies, Yellowstone National Park, Colorado Springs and many others.

The all-inclusive price is unusually low because of the coöperation of so many important medical societies. It is, therefore, recommended that our members avail themselves of this most attractive and unusual program which may not again present itself for some time. An attractive folder, describing these travel arrangements, may be obtained through the Secretary's office or the Transportation Agents, The American Express Travel Service, 378 Boylston Street, Boston, Massachusetts.

Necrology



James Alfred Spalding, 1846-1938

On Sunday, February 27th, at 6.15 P. M., Dr. Spalding died peacefully in his home at 627 Congress Street, Portland, Maine. During the last sixteen months he had been confined to his room because of a gradual failing in his strength. The death of Dr. Spalding removes from the ranks of the Maine Medical Association a beloved leader. A summary of his life in this medical journal for which he labored many years is inadequate, indeed, to portray the highlights and colors of a character so rich and colorful.

Dr. Spalding was born in Portsmouth, New Hampshire, on August 20, 1846, in a large white house which stands near the eastern side of the Hotel Rockingham. He was the son of Lyman Dyer and Susan Parker Parrott Spalding. He attended the Public School in Portsmouth and a note in his handwriting exists which states that he started to kindergarten with an older brother at the tender age of two years and ten days because he was a good talker and could answer questions for both. And the note adds that he started his study of languages at an early age, Latin and German being the first two. From the Portsmouth schools he entered Dartmouth College and was graduated with a degree of A. B. in June, 1866, about a month before his 20th birthday. After Dartmouth graduation he decided to study medicine as had his distinguished grandfather, Doctor Lyman Spalding, founder of the National Pharmacopœia. At Harvard he studied under Oliver Wendell Holmes, heard Brown-Sequard lecture on Internal Secretions, saw Doctor Bigelow perform the first litholapaxy in this country and associated with William James as a classmate. Deafness, which appeared slight, while at Dartmouth, became more pronounced during his years in Medical School. Doctor Holmes observed this and advised him upon graduation to go abroad and study diseases of the eye and ear. Therefore, after receiving his degree of M. D., in 1870 he embarked for study in London, Paris and Vienna. An interesting account of this period appears in the January, 1934, issue of the MAINE MEDICAL JOURNAL under title of "My Guardian Angel" and expresses Doctor Spalding's gratitude to Doctor Holmes. The years of study in foreign clinics not only offered an opportunity to enlarge his knowledge in diseases of the eye and ear but also to improve his understanding of various languages. Indeed, his proficiency in German, Italian and French gained for him employment in translating medical papers into English. And the zest for languages remained with him always, stimulating him to acquire knowledge of one after another and in his old age stirred him to engage in learning Gaelic. When time from study permitted he turned to music and learned to play the best of compositions on the piano, and for further relaxation he learned to play billiards, developed a graceful style of play and held his own with the best of amateur players, and always played to win.

With these accomplishments he returned to Portsmouth in 1872. In 1873, however, he moved to Portland. The following account of his decision to move to Portland written by him in 1931 throws light on his alert mind and energy: "On the 12th of August, 1873, when I had been practicing for a few months in Portsmouth, N. H., after my return from European studies, the newspapers of the day reported the deaths of Dr. Gilman Davies and Dr. George E. Hatton, who had just started eye practice in Portland. I packed up my bag and instruments at once and came to Portland, where I have now lived for 58 years." His long and useful life in Portland was filled with hard work and well-earned honors. After twelve years, in spite of many discouragements and his physical infirmity, he felt himself well established. He became a member of the Maine General Hospital Staff in 1881 and served as Ophthalmologist until 1914. He established Eye Clinics in Portland, Augusta and Bangor, and continued in active practice of his exacting specialty into his 85th year when a fractured hip disabled him. One case to which he often referred as pleasing him the most of his many cases was that of a man of 20 years totally blind at birth to whom he restored sight which lasted until the man was over 90. In addition to his large private practice and hospital service he devoted hours to the medical societies within and beyond the State. He served as President of the State Society in 1917-18, as Editor of the JOURNAL from May, 1933, to September, 1935, and as Necrologist from 1908 to 1936. He maintained after retiring from private practice a constant and eager interest in medicine and doctors of medicine. His office at 627 Congress Street bulged with medical books and papers. His correspondence, unique as the years rolled on, embraced people far and wide. Although his prime interest was medicine, he always nourished a warm interest in people and the lively arts. His home was a happy one. In 1882, November 15th, he married Sarah Chase Shepley, of whom he wrote in a short note on St. John's Day, 1923, "She was a good girl to me and I am what I am through her kind and gentle influence." They were both communicants of St. Luke's Episcopal Cathedral and attended Sunday morning service regularly. For many years the Doctor had been a Vestryman of the Lesser Chapter of the Cathedral, a staunch and loyal member.

He published numerous medical papers, wrote many medical biographies and two books, one published in 1917, entitled "Life of Dr. Lyman Spalding," the second in 1929, entitled "Maine Physicians of 1820." In 1928 his Alma Mater, Dartmouth, conferred upon him the Honorary Degree of Doctor of Letters. He returned to Hanover in June, 1936, for his 70th Commencement Anniversary, attended the President's reception, inspected many buildings, viewed without comment Orozo's Murals, insisted upon sitting through eight innings of the baseball game between Cornell and Dartmouth, made a graceful bow when introduced at the Alumni luncheon, in fact, enjoyed every minute of a gay and busy program. This proved to be his last visit to Dartmouth. At the time of his death he was the fourth oldest living alumnus.

The curtain has fallen on a distinguished career. The profession of medicine has lost a zealous disciple, his friends and associates a beloved companion, young men a stimulating inspiration. He knew well, better I suppose than anyone in Maine, three generations of Maine doctors, and he liked them all. And he labored for them and believed in them. He was as Dr. Edwin W. Gehring aptly said in an address upon the occasion of a dinner in Dr. Spalding's honor, September, 1931, "Nestor of the medical profession of Maine; man of broad culture, profound learning, and wide human sympathies, whose perennial youth startles and delights us."

T. A. F.

Notices

*Tumor Clinics**

Portland: *Maine General Hospital*, Thursday, 11 A. M.-12 M. Director, *Mortimer Warren, M. D.*

Lewiston: *Central Maine General Hospital*, Tuesday, 11 A. M.-12 M. Director, *E. V. Call, M. D.*

St. Mary's General Hospital, Wednesday, 4 P. M. Director, *R. A. Beliveau, M. D.*

Waterville: *Thayer Hospital*, Thursday, 9-11 A. M. Director, *Edward H. Risley, M. D.*

Sisters' Hospital, Thursday, 9-11 A. M. Director, *Blynn O. Goodrich, M. D.*

Bangor: *Eastern Maine General Hospital*, Thursday, 11 A. M.-12 M. Director, *Magnus F. Ridlon, M. D.*

* Approved by Maine Medical Association.

Crippled Children's Service

Lewiston: *Central Maine General Hospital*, 9-11 A. M., 1-3 P. M., Saturday, March 26th, April 30th, May 28th, June 25th.

Portland: *Children's Hospital*, 9-11 A. M., 1-3 P. M., Monday, March 14th, April 11th, May 9th, June 13th.

Bangor: *Eastern Maine General Hospital*, 1-3 P. M., Thursday, March 17th, April 21st, May 19th, June 16th.

American Board of Ophthalmology

1938 Examinations: San Francisco, June 13th; Washington, D. C., October 8th; Oklahoma City, November 15th.

Important: Applications should be filed immediately. Required number of case reports must be filed at least sixty days prior to date of examination. Application blanks can be procured from: Dr. John Green, 3720 Washington Avenue, St. Louis, Missouri.

American Board of Obstetrics and Gynecology

The general oral, clinical and pathological examinations for all candidates (Groups A and B) will be conducted by the entire Board, meeting in San Francisco, California, on June 13 and 14, 1938, immediately prior to the meeting of the American Medical Association.

Application for admission to the June, 1938, Group A examinations must be on an official application form and filed in the Secretary's Office before April 1, 1938.

The annual informal dinner and general meeting of the Board will be held at the Palace Hotel, San Francisco, on Wednesday evening, June 15, 1938, at seven o'clock. Dr. William D. Cutter, Secretary of the Council on Medical Education and Hospitals of the American Medical Association, will be the guest speaker, and the Diplomates certified at the preceding days' examinations will be introduced individually. All Diplomates are invited to attend the dinner meeting, and to bring as guests their wives and any persons interested in the work of the Board.

For further information and application blanks address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

Golfers' Special

A five and one-half days' ocean voyage from New York to New Orleans on the $2,500,000 S. S. *Dixie* starts off the "Golfers' Special" on a delightful trip to San Francisco for the American Medical Association Meeting next June. Sponsored by the American Medical Golfing Association, the Special will feature six games of golf on the trip to the coast and include sightseeing stops in New Orleans, Houston, Galveston, San Antonio, Los Angeles and Del Monte.

The Twenty-Fourth Tournament of the American Medical Golfing Association will be held in San Francisco at the luxurious Golf and Country Club on Monday, June 13, 1938. This is a thirty-six hole annual competition.

On the return journey of the "Golfers' Special" through Portland, Seattle, Vancouver, Lake Louise and Banff, two games of golf and an all-day boat trip up Puget Sound will be enjoyed.

Non-golfers as well as medical golfers, and their ladies, will be welcome on the Golfers' Special. The all-inclusive summer rate on the Special train will include air-conditioned de luxe Pullmans, with compartments and drawing rooms only.

For full particulars on the Golfers' Special, and on the A. M. G. A. tournament in San Francisco, write the President of the A. M. G. A., Dr. Walt P. Conaway, 1723 Pacific Avenue, Atlantic City, New Jersey, or Bill Burns, Executive Secretary, 731 N. Capitol Avenue, Lansing, Michigan.

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Book Reviews

"Eyestrain and Convergence"

By N. A. Stutterheim, M. D., Part-time Ophthalmic Surgeon to the Johannesburg School Clinic, Transvaal Education Department; Late Assistant Eye Clinic, University, Leyden.

Published by H. K. Lewis & Co., Ltd., London, 1937. Price, 7s.6d. net.

With this book the medical profession is presented with what appears to be an original work in ophthalmology. The author, stimulated by the works of Sherrington and others and by years of trial and error along conventional lines, discovered that through refraction work nobody has as yet solved the very urgent problems in one of the most important departments of medicine, namely, ophthalmology.

For the years past he has treated eyestrain on the principle of movement. He has learned that physiological factors, hitherto neglected, have to be taken into account in order to solve the problems confronting the private ophthalmologist. Out of all this experimental work was born a new conception of kinetic binocular ophthalmology. Asthenovergence is the term selected by the author to describe insufficiency of convergence, which insufficiency is very prevalent among the various groups of intelligent workers, but differs for each group as well as for each member within the group. This insufficiency seems to be the chief reason for a large variety of symptoms, commonly included in the indefinite symptom-complex term called eyestrain. In the author's opinion asthenovergence is a disorder of so central a character that it will spread its influence far and wide into the central nervous system.

Dr. Stutterheim has devised a method of physiological therapeusis of his own and seems to have had very good results. He states, "Kinetic treatment of asthenovergence has proved itself an invaluable addition to the armamentarium of the medical practitioner." There is a clear description of this treatment, equipment and technique used by this author, which description is supplemented by a tabular summary of one hundred cases treated by this method. A more detailed description of an additional number of successfully treated cases terminates this interesting book.

"Operative Gynecology"

By Harry Sturgeon Crossen, M. D., Professor Emeritus of Clinical Gynecology, Washington University School of Medicine; Gynecologist to the Barnes Hospital, St. Louis Maternity Hospital, and St. Luke's Hospital; Consulting Gynecologist to De Paul Hospital and to the Jewish Hospital and Robert James Crossen, M. D., Assistant Professor of Clinical Gynecology and Obstetrics, Washington University School of Medicine; Assistant Gynecologist and Obstetrician to the Barnes Hospital and the St. Louis Maternity Hospital; Gynecologist to St. Luke's Hospital and to De Paul Hospital.

5th Edition. Published by The C. V. Mosby Co., St. Louis, 1938. Price, $12.50.

After a lapse of seven years the authors found it necessary to bring out this new revised edition. New knowledge is accumulating very rapidly in all of the medical sciences and it needs to be brought together into convenient book form. Some of the older views need clarification. Special emphasis is placed by the authors on the special reasons for operation. In this Fifth Edition about two hundred new illustrations have been used, bringing the total number to twelve hundred and sixty-four. Pictorial description of the various steps in the progress of a surgical operation always renders a textbook more valuable and the operator's technique more easily understandable.

A special feature of this book is the authors' elaboration of the question, "Is operation indicated?" in dealing with pelvic symptoms in a "nervous" patient. "Symptoms are the behavior-manifestations of the individual as a unit, and hence are the result of the various influences and forces at work in that unit."

The authors very strongly advise the physician who is confronted by a "nervous" patient with gynecological symptoms to make an accurate history and examination; to consider how far the pelvic lesions themselves will rationally account for the symptoms; to think seriously of the possibility of the presence of endocrine, allergic, hormonic, etc., functional abnormalities; to weigh the possibility of sensorimotor system diseases; and above all, to reassure himself that the patient under his immediate care is not laboring under a neurosis or a psychosis. Those members of the profession who had some experience in the post-operative care of the types of patients above mentioned as poor operative risks, will thank the authors for their insistence in pre-operative foresight for the prevention of post-operative complications of prolonged mental invalidity and disharmonious physician-patient relationship.

"The Spectacle of a Man"

By John Coignard. Published by Jefferson House, New York, 1937. Price, $2.50.

This book, published under a pseudonym, apparently was written for the purpose of popularizing psychotherapy by the psychoanalytic method. In order to produce a readable account of the progress made by the patient during the many months he visited the psychoanalyst, the material was clothed into the language of a novel.

The author tries to show that in man's moral life the principles of "good" and "bad" are always struggling with each other for leadership, first one, then the other. He states that "many of the religions have been founded upon a worship of the so-called Good Principle without accepting the hint explicit in the dualism found in all natural phenomena that both are necessary, that neither can be outlawed. Thus theory and instinct must be accepted, not as Desirable and Undesirable, or the so-called Good and Bad, but necessary to each other, each infinitely valuable to man, as are all the opposite principles, both in nature and man, the soul and the senses, passivity and activity, Heaven-bound and Earth-bound, restraint and exultation, form and feeling, love of one's neighbor and love of oneself." Normally, "When an instinct is used it revolves out of sight, and in its place is theory; the senses are followed by the soul, as night by the day. Human life must be a sequence, a revolving, a changing of the tides, a merging of one principle into another, not an attempt to live one part of life without its opposite." Abnormally "Life is not a sequence of the senses and the soul, as night displaces day, but rather neither instinct nor theory are ever completely dismissed. Both are involved in every thought and action. They produce a conflict within themselves of these two warring impulses neither of which ever obtains undiluted expression." The state which results from this struggle is a form of neurosis which in many cases has been beneficially influenced by the psychoanalytic method. It is this reviewer's opinion that the popularization of psychoanalysis as a therapeutic agent presents to the practitioner the same two edges of the sword that hangs over the heads of many popularizers of such therapeutic agents, systems or methods which in the opinion of the inventor promise relief from conflict, fear, worry and disease but which, in the hands of financially successfully manipulating popularizing promoters, tend to simply overwhelm the public with verbal showers of glitter which is not all gold, and instead of successfully treating chronically persisting and chiefly not remediable though pain-

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Chemists to the Medical Profession. MMJ3-38

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ful human situations and of solving problems, they create new problems with new fears and worries by forcing into the people's consciousness new doubts about their own health and their own good innate common sense.

Practicing physicians who are interested in the workings of the psychoanalytic method of therapy in neuroses should know the principles of psychoanalysis. The little volume under review might be satisfactory to some but most genuinely interested practioners, no doubt, will be more satisfied by studying the more technical works of recognized authorities.

"Twenty-five Years of Health Progress"

A study of the mortality experience among the Industrial policyholders of the Metropolitan Life Insurance Company, 1911 to 1935.

By Louis I. Dublin, Ph. D., Third Vice-President and Statistician, and Alfred J. Lotka, D. Sc., Assistant Statistician, with the collaboration of the staff of the Statistical Bureau.

Published by Metropolitan Life Insurance Company, Home Office, New York, 1937.

By special inquiries directed to thousands of physicians, coroners, medical examiners and hospital superintendents, and by systematic arrangement of the factual information received, the Metropolitan Life Insurance Company has compiled this book of 611 pages of statistical data. The work is addressed to health officers, physicians, sociologists, life insurance officials, and to many others among the various professions who are interested in the health and welfare of the wage-earning American. Many of the readers will be gratified to know that they themselves have contributed their share in the accumulation of accurate data as published in this book. It appears that a selected group of libraries may obtain a copy for their shelves, so that their clients may be able to learn of the vital facts which tend to influence our life experience.

"The Compleat Pediatrician"

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By Wilburt C. Davison, M. A., D. Sc., M. D., Professor of Pediatrics, Duke University School of Medicine, and Pediatrician, Duke Hospital. Formerly Acting Head of Department of Pediatrics, the Johns Hopkins University School of Medicine, and Acting Pediatrician in Charge, The Johns Hopkins Hospital. Fellow American Academy of Pediatrics and American College of Physicians. Member White House Conference, American Pediatric Society, and American Board of Pediatrics.

Durham, N. C., printed by Seeman Printery for Duke University Press, 1938. Second, Completely Rewritten Edition. Price, $3.75.

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This book is one of a group appearing in connection with the Duke University Centennial, celebrating in 1938 the centenary of the origin of Trinity College from which Duke University developed. The general structure consists of seven chapters, headed: Respiratory; Gastro-Intestinal; Skin and Contagious Conditions; Neuropsychiatric; Circulatory; Genito-Urinary Conditions; Bone, Muscle, Cartilage, Spine and Joint Diseases; then there is a chapter on laboratory and other procedures; one on nutritional requirements, feeding and diets; one on general, fluid, oxygen and physical therapy; one on growth, development and general care of children, prematurity and the reduction of mortality; one on history taking and physical examination; and lastly, one on drugs and prescriptions frequently used in pediatrics.

The enthusiasm with which the first edition was received everywhere no doubt will accompany the present second edition in even greater measure. The work is a masterpiece in pragmatic epitomization of comprehensive completeness and reliable authenticity.

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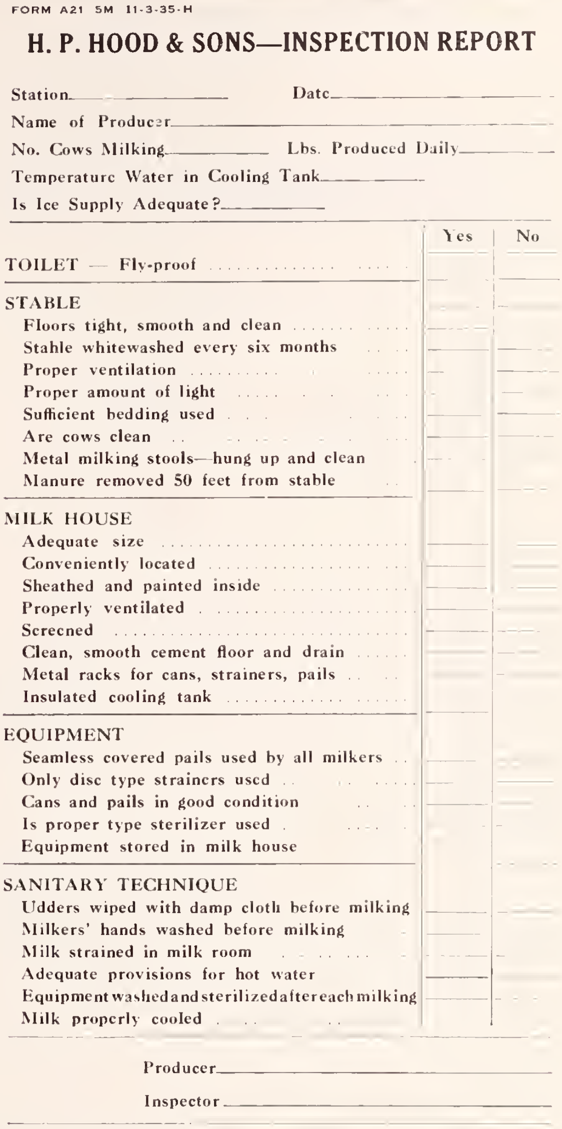

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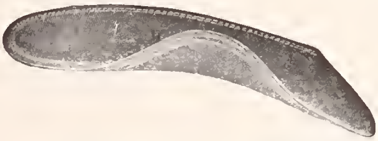

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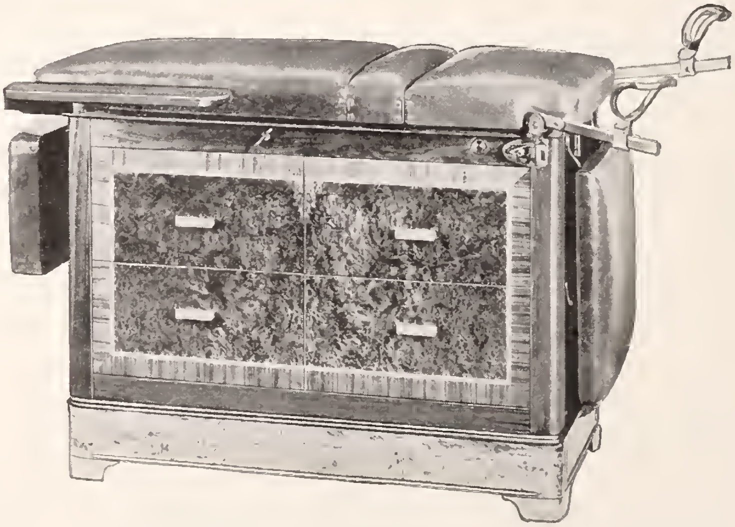

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**Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245*
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N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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II. THE BLANCH

● Previously, we have described the reasons for the thorough cleansing of raw food materials prior to canning and the methods by which such cleaning is effected. Another basic operation in the commercial canning procedures for many vegetables and some fruits, is known as the "blanch". (1)

In essence, the blanch is an operation in which raw food material is immersed in warm or hot water, or exposed to live steam. The blanch serves a multiple purpose.

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Such, in broad detail, are the purposes and mechanics of the blanch, a basic operation in many commercial canning procedures.

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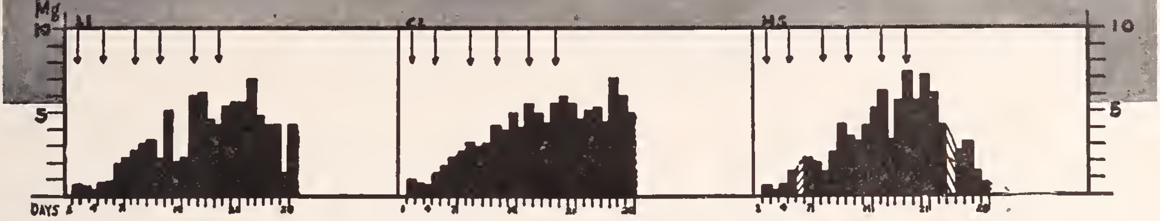

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[1] Sollmann, T., Cole, H. N., Henderson, K., *et al.*: *Amer. J. Syph. Gon. & Ven. Dis.* 21:480 (Sept.), 1937.

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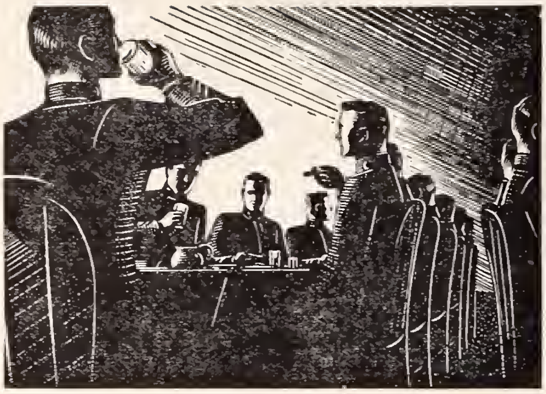

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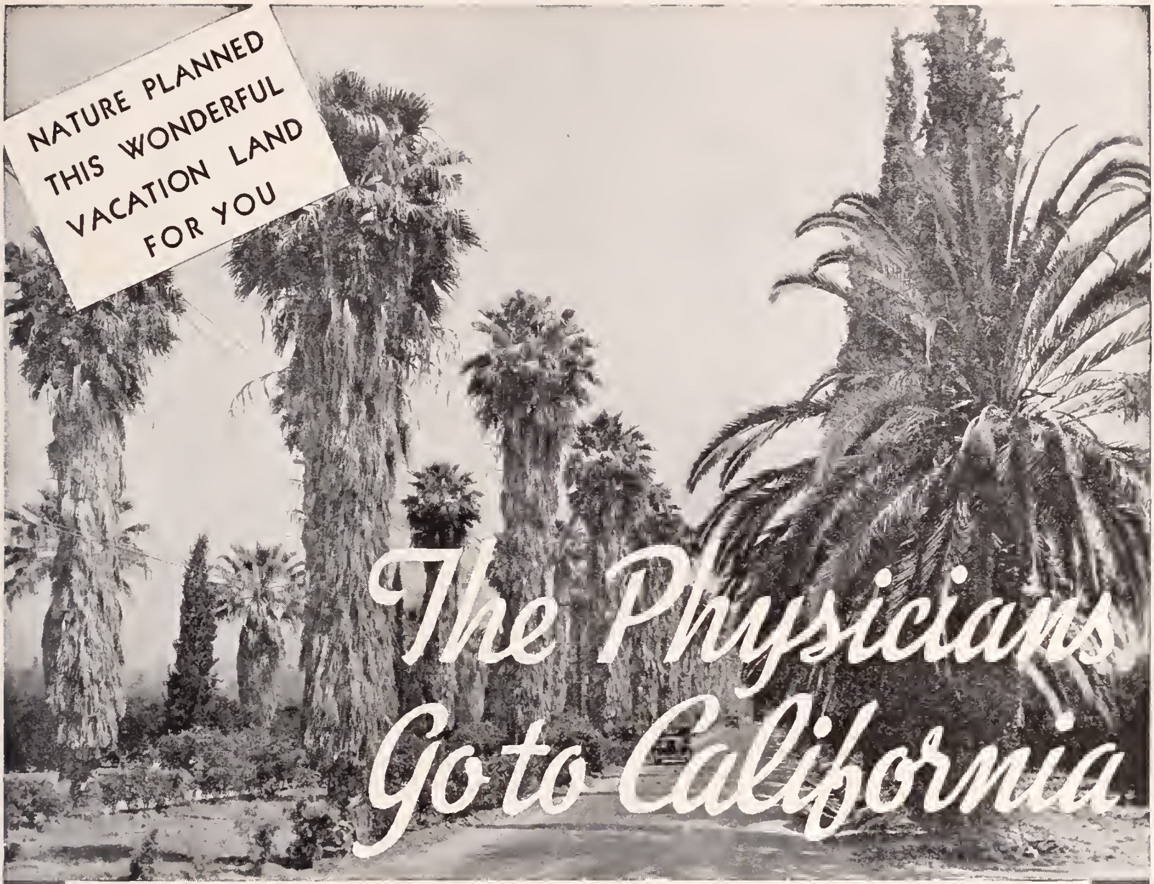

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*Clinicopathological Case Reports**

A Case of Mastoiditis and Influenzal Meningitis: Recovery

By Charles H. Gordon, M. D.,
Portland, Maine

R. L., a boy seven years old, was admitted to the Maine General Hospital mid-afternoon October 9, 1937.

About two and one-half weeks previous to admission he contracted an upper respiratory infection. Four or five days later, for a short period of time, there was a dull pain in the left ear. This was soon followed by a seropurulent discharge, and the pain ceased.

The child attended school, had no other symptoms than the discharging ear (which had not been treated in the interim) until October 5th.

During the forenoon of October 5th, he had a headache, which increased in severity, and was followed by nausea, vomiting and later delirium.

He was referred to the Farrington Hospital two days later, on October 7th.

The findings by Dr. Casperian at the hospital were as follows: Temperature 103, pulse 130, respirations 26. A pale, very sick-looking child, dehydrated, stuporous, and at times delirious. There is a marked stiffness of the neck muscles and a bilateral Kernig's is present. The nasal and pharyngeal membranes are congested. The left auditory canal is filled with pus, the eardrum bulging and perforated, mastoid tenderness questionable.

Lumbar puncture revealed a cloudy fluid under pressure. This was sent to Dr. Mortimer Warren for examination. Subsequent lumbar punctures were done every eight hours.

Dr. Mortimer Warren's report on the spinal fluid: Slightly cloudy, few fibrin shreds. W. B. C. 390; Polys 97%; Globulin + +; reduction normal. After standing: Few fine pleomorphic gram negative bacilli found in smear. After 48 hours obtained faint growth of gram negative bacilli with other cocci.

I examined the patient with Dr. Casperian at the Farrington Hospital on October 9th, and advised that the patient be referred to the Maine General Hospital for mastoid X-rays and operation.

The patient was admitted to the Maine General Hospital that afternoon, mastoid X-rays were taken, and a mastoid operation was soon performed.

X-ray report by Dr. Langdon Thaxter:

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* The Case Reports appearing in this issue were presented at the Clinical Session of the Maine Medical Association held in Portland, October 21-22, 1937.

The mastoids are undeveloped, the cells being of the diploic type. There are no cells seen over the petrous area, which appears to be normal. The cells on both sides are normal so far as can be seen.

Blood examination: R. B. C. 3,800,000; W. B. C. 15,800; Hb. 65%; Polys 80%; Lymp. 13%; Mono. 7%.

Mastoid Operation: The usual post-auricular incision was made. The mastoid cortex (which was thin) was removed with a hand gouge and rongeur. The cells were definitely of the diploic type, containing droplets of sero-pus in various areas. The lining membrane of the cells was edematous and bled very freely. The cellular area was exenterated with curettes and burrs, and considerable decalcification was present.

In carrying the procedure further, the bony plate of the lateral sinus was removed from the mastoid tip to beyond the knee of the sinus. It apparently was not involved.

The posterior-superior canal wall was next removed to facilitate further exploration of the area, and removal of the roof of the middle ear cavity and mastoid antrum for examination of the dura.

Whereas the cellular area of the mastoid was considerably softened and decalcified, the roof was very hard. However, after removal of a small area of bone, the adjacent dura was markedly congested. A larger area of bone was removed until the dura appeared normal. A drain was inserted and the wound was left open. The patient's condition was rather poor as he was returned to the ward following the operation.

The following day the child's condition was definitely better. His headache was remarkedly less, the temperature was 100 by rectum, and delirium was absent.

The treatment consisted of the usual post-operative care of the mastoid wound. Lumbar punctures were done every eight hours for the first two days, and were later done at twelve and twenty-four hour intervals.

Prontylin was given in five and ten grain doses every four hours. Six 5 c.c. doses of prontycil were given at four-hour intervals.

On October 13th and 15th transfusions of 250 c.c. of citrated blood were given.

Recovery was rapid and uneventful and the child was discharged from the hospital on the 27th day of October.

Dr. Mortimer Warren's report on examination of the spinal fluid:

R. L. Summary of Laboratory Findings to Date

#B767/37 — 10/8/37 — Farrington Hospital:

Spinal fluid: Slightly cloudy; few fibrin shreds. W. B. C. 390; R. B. C. 30; Polys 97%; Globulin ++; reduction normal.

Report: After standing, few fine pleomorphic gram negative bacilli found in smear; after 48 hours obtained faint growth of gram negative bacilli with other cocci.

#7540 10/9/37

Spinal fluid: Small amount; W. B. C. 180; R. B. C. 100; Polys 35%; Monos 65%; Globulin +; reduction present.

#7552 10/10/37

Spinal fluid: Ground glass appearance; W. B. C. 140; R. B. C. 50; Polys 40%; Monos 80%; Sugar 60 mg.; NaCl 740 mg.; Gold Curve 000120000.

#7598 10/11/37

Spinal fluid: Bloody; W. B. C. 20; R. B. C. 4,700. Smear and culture: Scanty growth of gram negative pleomorphic bacilli.

#7698 10/12/37

Spinal fluid: Slightly cloudy; W. B. C. 10; R. B. C. 1,400. Smear and culture negative.

#7695 10/13/37

Spinal fluid: Slightly cloudy; W. B. C. 7.5; R. B. C. 650. Not cultured.

In fluids of 10/8/37, 10/9/37 and 10/10/37 Obtained fine growth of pleomorphic gram negative hemophilic bacilli, along with incidental staphylococcus albus. This bacillus culturally and morphologically corresponds to the Hemophilus Influenzæ.

#4428B 10/10/37

Mastoid culture: Hemolytic Streptococci with S. P. Albus.

COMMENT

This case is of more than usual interest in consideration of the fact that a generalized meningitis is so frequently fatal.

Organisms were present in the spinal fluid previous to the mastoid operation, and on the two subsequent days.

The bacteria disappeared subsequent to a complete mastoidectomy, and a wide decompression of bone of the floor of the middle fossa.

It is also to be noted that the spinal fluid bacteria were influenzal bacilli, and that the mastoid culture revealed a hemolytic streptococcus.

These findings prompt the question: Was the meningeal infection caused by the mastoid involvement or did it arise from another focus of infection? These facts were had only after having done the mastoid surgery. However, in consideration of the fact that the child's condition improved rapidly and progressively following the mastoid operation, it would appear that the mastoid infection was the primary focus.

Another point of interest is that the X-ray examination of the mastoids did not coöberate the clinical diagnosis of acute mastoiditis. This experience, while not usual, is by no means a rare one.

An examination of the spinal fluid is most essential in arriving at a correct diagnosis.

Not infrequently do we see cases which have a cloudy spinal fluid and a varying number of cells, but no organisms are present. Such cases indeed offer a different prognosis than one where organisms are recovered from the spinal fluid.

The term "Generalized Meningitis" should be reserved for those cases which have bacteria present in the spinal fluid.

Brain Abscess—Case Report

By H. EUGENE MACDONALD, M. D.,
Portland, Maine

B. B., a 12-year-old girl, was admitted to the Maine General Hospital April 17, 1937.

Complained of headache for three weeks. This was preceded by an earache without discharge. During this time she had some pain over an eye with nausea and vomiting. None of this vomiting was projectile.

Examination: Right ear showed a dull membrane. Both discs blurred and a questionable Babinski on both feet.

She looked, on examination, like a patient with an increased intracranial pressure without localization.

Lumbar puncture; cloudy fluid 250 mm. pressure, 285 cells, 64% polys, 37% lymphs, sugar 50 mgm. No bacteria or tbc. found. White blood count 12,000.

Following this there was some improvement and a sense of euphoria.

Von Pirquet was negative.

On May 2, 1937, lumbar puncture 700 mm. pressure. At this time she developed a squint. Some hours after she dropped her respirations to five per minute. This lasted a few hours and then returned to normal.

X-rays of the skull showed old sclerosed mastoids and a questionable diminished density in the parietal bone. She next developed a bilateral abducens palsey with a cut in the left temporal and right nasal visual fields.

This was sufficient to confirm a localization in the right temporal lobe of the brain. The mechanism causing the pressure was unknown.

Osteoplastic craniotomy exposed a tense brain under much pressure and an abscess was opened and emptied of more than sixty cubic centimeters of pus in the right temporal lobe. Then the wall of the abscess was removed in toto.

Following this she began to improve and slowly the palsies disappeared. She had a small leak from the scalp wound which soon stopped.

Followed through the out-patient department a discharge from the scalp wound was reported. This proved to be pus. She showed signs of a sequestrum under the scalp and was readmitted to the hospital on October 1, 1937.

X-rays showed definite osteomyelitis of the bone flap. On October 7th she was reopened and the flap removed. Much granulation was removed at the same time from the dura. She did not have any intracranial pressure above normal. She recovered from this affair well and was discharged on November 16, 1937.

She has as a result of this infection and its pressure lost some vision in the right eye, otherwise she has done well.

Case Report

Clinical Presentation by W. F. W. Hay, M.D., Portland, Maine

Pathological Presentation by F. F. Ferguson, M. D., Portland, Maine

F. R., an unmarried white woman, aged 63, was admitted to the Medical Service, September 8, 1937.

She complained of progressive enlargement of the abdomen of six weeks' duration. During this time her appetite had been poor and she had had continuous epigastric distress but no nausea or vomiting. Her bowels had moved only after taking salts; no abnormal stools had been noted. There were no urinary symptoms except for the fact that she had passed less urine than usual during the present illness. Her ankles had been swelling during the daytime.

Past history was essentially negative. She had been well up to one year ago, when she began to have dyspnea on exertion and occasionally precordial pain which had no relation to effort. She had had a non-productive cough for two years. Menopause had occurred at the age of 50; there had been no bleeding or discharge since then.

Her father was said to have died of cancer of the stomach and her mother had tuberculosis.

Physical examination revealed a well-developed and nourished, middle-aged woman. The temperature was 98.6, the pulse 104, and the respiration 20. Head, eyes, ears, nose were negative. The teeth were false. No enlargement of cervical glands. No masses were felt in the breast. Expansion of the lungs was limited, the breath sounds were vesicular and no rales were heard. The heart showed no enlargement, the rhythm was regular, the sounds of good quality and there were no murmurs. The blood pressure was 130/70. Her abdomen was markedly distended and a distinct fluid wave could be elicited. No organs or masses could be felt because of the distention. No edema of the extremities was present. The reflexes were normal. On pelvic examination there was a large fixed mass.

Laboratory findings: Hgb., 55%; R. B. C., 3,400,000; W. B. C., 4,150; neutrophils, 59%; lymphocytes, 37%; monocytes, 4%. Urine on admission, cloudy, acid; S. G., 1.021; no sugar or albumin; acetone and diacetic acid 3 plus. Sediment, occasional W. B. C. and epithelial cell. Urine four days later, no acetone or diacetic acid. Blood Kahn and Hinton were negative.

Two days after admission her abdomen was tapped and eight quarts of clear, straw-colored fluid withdrawn. Laboratory report of this fluid: S. G., 1.020; albumin, 38% by bulk; R. B. C., 50 per H. P. F.; W. B. C., 71 per H. P. F.; 93% lymphocytes and 7% endothelial cells. No bacteria were found on smear or culture.

She was seen in consultation by the gynecological service, and an exploratory laparotomy was advised. This was done on September 14, with the following report: Free fluid in the abdominal cavity. Peritoneal surface was everywhere studded with small whitish papules about 1 mm. in diameter. The omentum was wrapped around the transverse colon, forming a hard band. The liver was small and smooth. The uterus was enlarged and very firm. Tubes were normal and bound down with very firm adhesions. Ovaries were small and atrophic.

The differential diagnosis was between tuberculous peritonitis and carcinomatosis. The biopsy of the peritoneum, however, was reported as a small collection of cords and strands of epithelial cells in a fibrous stroma, with little tendency to form glands or alveoli, and which bore much resemblance to scirrhous carcinoma of the breast. The breasts were carefully examined again, but no masses could be felt.

She developed a broncho-pneumonia and died on the 10th post-operative day.

Pathological Report

The post-mortem findings briefly were as follows: 1) scirrhous carcinoma of the right breast with abdominal and axillary metastasis and abdominal carcinomatosis with ascites; 2) atelectasis lower lobes, both lungs, with broncho-pneumonia, right, and chronic pleurisy; 3) chronic nephritis; 4) uterine fibroids.

The most interesting findings were in the abdomen and in the right breast. There was still about 300 c.c. of fluid remaining in the abdominal cavity, and extensive peritoneal adhesions were present. The surface of both large and small intestine was studded with small white slightly raised nodules, averaging 2-3 mm. in diameter. Similar nodules also studded the mesentery, and the omentum was matted together to form a band running diagonally across the abdomen from the appendix to the splenic flexure of the colon. The transverse colon, stomach, and duodenum were adherent to one another, and the surface of the stomach was studded with similar nodules. They were also present in the remains of the lesser sac and over the crura of the diaphragm, but the liver was relatively free from these nodules, except over the surface of the left lobe. The appendix was bound down by the adhesions and its surface studded with similar nodules; the tip of the appendix was enlarged to 1.1 cm. in diameter and its lumen obliterated by firm white tissue. There was a mass in the pelvis which consisted of one large intramural fibroid 11 cm. in diameter and several of smaller size. There were numerous nodules over the surface of the uterus, in the pouch of Douglas, and over the tubes, but the ovaries were small and sclerotic. No nodules were found in the pleural cavities.

All sections from the abdominal nodules showed invasion of the peritoneal surface by strands and cords of epithelial cells resembling scirrhous carcinoma of the breast, as was seen in the biopsy specimen.

The tumor in the right breast was not palpable, even at post-mortem, but gross sections of the breast revealed one small gritty nodule 1 cm. in diameter in the substance of the breast under the nipple, not connected with it. There were also two small nodules in the right axilla, but no others were found in the right breast and none in the left breast. It was not possible to trace any strands to the axilla or to the deep lymphatics.

Microscopic sections of the nodule in the right breast showed scirrhous carcinoma and there was metastatic carcinoma in the axillary glands. These were very similar in appearance to the peritoneal nodules.

According to Ewing, peritoneal invasion is a fairly common late complication of breast cancer, which has been shown by Handley to occur chiefly by way of the epigastric lymphatics. It is certainly unusual, however, for such a small and practically undiagnosable primary tumor to cause such extensive metastases.

(Dr. M. C. Winternitz of Yale University was present when this case was presented, and had previously studied the sections. He agreed with the diagnosis of carcinoma of the breast with abdominal metastasis, and brought out the point that the peritoneum furnishes an excellent incubator for the growth of any type of tumor which reaches it, so that the growth of the peritoneal metastases may be more rapid than that of the original tumor.)

Three Cases of Partial Rupture of the Ureter Due to Ureteral Calculi with Extravasation of Urine Into Abscess Pocket

(All cases were within a period of fourteen months.)

By Harry L. Curtis, M. D.,
Portland, Maine

Case I. The first patient was a man, age 43 years, who entered the Maine Eye and Ear Infirmary on June 20, 1936. He had been taken with a severe pain in his left side and back while on a train on which he was employed. Several years before he had had an attack of renal colic and had a cystoscopic examination in Toronto, Canada. Had been well ever since. Family history negative.

Physical examination revealed tenderness in the left costo-vertebral angle and in the right upper quadrant anteriorly. The left lower extremity showed a large scar due to shrapnel wound during the World War. The rest of the physical examination was essentially negative. His pain still persisted and could be controlled only with morphine, so an X-ray plate was taken on June 27, 1936. The film revealed a small triangular calculi at the level of the fourth lumbar vetebræ on the left side. Next on June 29, the patient had a cystoscopic examination and a pyelogram was done on the left side after the ureteral catheter had been inserted and 15% sodium iodide injected. This showed a calculus in the left ureter and an extravasation of the sodium iodide through a hole in the ureter into an abscess pocket. He was operated on June 30 and the ureter found to be in a mass of scar tissue, and the abscess pocket below the lower pole of the left kidney was opened and two ounces of pus removed. The calculus was felt but it moved and could not be located even though an X-ray was taken on the operating table. This incision was sutured and a drain left in the abscess pocket.

X-ray plate taken on July 18 showed another shadow in the right kidney which was about the size of a marble. On July 22 an intravenous injection of Diodrast was given with the same finding, namely bilateral ureteral calculi. Left ureter completely obstructed with a fistula draining through incision where drain had been, and poor renal function on both sides.

I saw this patient in consultation on August 7 and verified the above findings.

All the urine was draining through the fistula on the left side, due to the obstructed ureter, and a triangular calculus now appeared to be outside the ureter. The large renal calculus in the right kidney did not seem to be obstructing.

The laboratory reports were as follows:

Blood calcium	10 mg.
Phosphorus	2.6 mg.
Hemoglobin	66%
W. B. C.	9,900
R. B. C.	3,460,000
Blood urea	11 mg.

Kahn and Hinton negative, and the urine was loaded with pus, two to three red cells, no casts, no crystals, no T. B., but a mixed culture of staphylococci and gram negative bacilli.

On August 10 he stopped voiding urine completely but continued to drain urine through fistula in the left side. Two days later, another cystoscopic examination and the right ureteral calculus which was obstructing was pushed back into the renal pelvis, and a ureteral catheter left in the right side for drainage. The left ureteral catheter could only be inserted up to the point where the ureteral calculus had been or at the level of the fourth lumbar vertebra. The fistula tract was injected through a soft rubber catheter with sodium iodide at the same time an injection of sodium iodide was made through the left ureteral catheter, which showed the obstruction of this ureter and its relation to the fistula. Both kidneys showed pyelo-nephritis with a very poor function with intravenous indigo-carmine test. The patient was allowed to drain for ten days to improve this function and Methenamine given. There was no choice in this case, the first operation had to be on the right side to repair the best kidney. This kidney had an intrarenal pelvis and a short pedicle and so a small incision was made in the outer curvature of the kidney and a soft phosphatic calculus removed and a nephrostomy tube inserted for drainage. This was sutured and the oblique incision was sutured with chronic catgut and silkworm and two cigarette drains left in. This side was X-rayed again November 6 and showed no calculus present. The renal function according to dye test had improved a great deal and seemed satisfactory for a second operation. Another attempt was made to pass a dilator by the obstruction in the left ureter without success. The function still was very poor on this side. The left kidney area was operated on and the ureter found tied up in scar tissue from periureteral infection from the lower pole of the kidney nearly to the brim of the pelvis. As it was so difficult to free the ureter and seemed impossible to repair it and remove the calculus, there were only two operations of choice, either a permanent nephrostomy tube in this kidney or a nephrectomy. Due to his age and a satisfactory function in the other kidney, the latter seemed preferable and was done. This healed up very well, and the right kidney now had a very good function and the patient left the hospital cured.

This case was especially interesting for the following reasons:

First. Because he had three operations while in the hospital. First operation, incision and drainage of periureteral abscess. Second a nephro-lithotomy on the right kidney. Third, nephrectomy of left kidney.

Second. Cases of bilateral ureteral and renal calculi are not frequently met with.

Third. Rupture or perforation of ureter with extravasation of urine into abscess pocket is a rare condition.

Case II. Five months later I saw another case in a male patient, aged 22 years. This was the same as the first case except the abscess pocket was on the right side and about the same distance below the lower pole of the kidney. The calculus on this side was much smoother and the early diagnosis in this case had been intestinal obstruction, due to his vomiting and abdominal distention. This disturbance was relieved by enemas and laxatives and he was released from the hospital four weeks before this, but as he became worse he was again referred to the hospital. He had a cystoscopic examination and pyelogram taken and the following diagnosis made:

First: Bilateral pyelo-nephritis due to colon bacilli and very poor kidney function in both sides.

Second: Bilateral calculi. On the left side were three large renal calculi.

On the right side a small ureteral calculi with a ruptured ureter and the extravasation into the abscess pocket.

The patient had been in the hospital with a fractured spine, eight months prior to this, and had as a result a paralysis of both legs and no lateral flexion of the spine.

After draining this right kidney through a ureteral catheter for a number of days, he was operated on, repairing the kidney with poorest function first. The kidney was found to have a very short and fixed pedicle, also an intra-renal pelvis. The abscess of the ureter below the lower pole of the kidney was opened and drained, the ureteral calculus having been pushed up into the renal pelvis a nephro-lithotomy was done, and calculus removed. A nephrostomy tube was left in the kidney because of poor function.

After this incision healed he was allowed to be up in a chair, but renal colic in opposite side caused him to remain in bed. After function had shown satisfactory improvement, the tube was removed. Left side was now operated on and also was found to have a very short pedicle and a nephro-lithotomy done. Two large faceted calculi were removed from the pelvis, another large soft phosphate calculus was also removed, but a small calculi, fixed in the renal tissue in the lower pole of the kidney, was not removed. After this healed, patient again up around, but developed a slight bronchial pneumonia.

This case was of interest for same reasons given in Case No. I, but was seen earlier and both kidneys were saved.

The fixed spine, due to previous fracture, made it more difficult to perform nephrolithotomy.

Case III. This patient, also male, aged 48 years, seen in consultation at Maine Eye and Ear Infirmary.

After having indulged in excessive drinking was taken with pain in right side but not of a severe nature. Slight nausea, some abdominal distention, carried temperature, and urine loaded with pus. Cystoscopic examination with pyelogram done, showing no obstruction in left ureter but pyelo-nephritis with poor function. Right ureter was obstructed about five inches from ureteral orifice and a ureteral catheter inserted with difficulty. This kidney showed hydronephrosis and a dilated ureter in the upper part. The sodium iodide extravasated through a hole in the ureter into an abscess pocket which was a little lower than in preceding cases. There was also a stricture in lower part of ureter. I believe there was a ureteral calculus which the X-ray failed to show. Bladder showed signs of inflammation and a urine culture showed staphylococcus infection.

This kidney was drained as in preceding cases until pyelogram and renal function were satisfactorily improved. The right side was then operated on, abscess drained, and a nephrostomy tube left in. This kidney continued to improve until it was 50% better than upon previous examination, and much better than function on opposite kidney. This kidney was also saved. In this case I was unable to find a ureteral calculus, but believe one was present. In a report from the Mayo Clinic, bilateral calculi were present in one out of 640 cystoscopic examinations, thus not very common. I think, however, that in the 3500-4000 cystoscopic cases I have done a slightly higher percentage has been shown. The ruptured ureter with abscess formation are even less common, averaging 1-1250 cases. These are the only three cases I have seen, but they cannot be disregarded as results are very disastrous and the kidney on the ruptured side usually has to be removed unless an early diagnosis is made.

The symptoms are usually more severe than in an ordinary case of either renal or ureteral calculus in these cases.

Diagnosis is made only by cystoscopic examination, with pyelogram, and ureterograms.

Sulfhemoglobinemia

By Philip H. McCrum, M. D.,
Portland, Maine

Mrs. L., age 18, a primigravida, entered the hospital on June 2, 1937, with a history of vomiting all day accompanied by a severe headache. Her past history showed that she had had Scarlet Fever as a child. The family history was negative except that her mother had died of Bright's disease.

Her last catamenia was on Oct. 14, 1936, and the pregnancy was normal until the day of admission. The patient appeared sick and had a blood pressure of 154/90. Urine showed 5 mg. of albumen. There was no edema. The uterus appeared near term—Vertex in R. O. A. position—not engaged—cervix not dilated or taken up. Fetal Heart in the right lower quadrant 130—intercristal, interspinous, and external conjugate measurements were 25, 21, 18 respectively. The patient was not in labor.

In view of the elevated blood pressure and vomiting, a medical induction of labor was tried on June 3, but labor did not result. However, the blood pressure dropped to 120/80 and the vomiting stopped. After two days of rest, although her condition improved it was felt that labor should be induced on account of the small pelvic measurements and the early toxemia.

One June 6, a rectal tube was inserted and left for 12 hours with little effect. Small doses of pitocin (3 min) and then of thymophysin were given on June 7. Dilitation of cervix at 10 A. M. was 1½ fingers. Slow progress was made and delivery was accomplished with low forceps at 1.50 P. M., on June 8, of a 4 lb. 15½ oz. baby. At this time a profuse discharge of foul pus was noted — colon bacillus in type. 1000 cc of 50% alcohol intrauterine douche was given and considerable frank pus was washed out. Placenta showed the rectal tube had caused a furrow in it and there was evidence of infection along the margin. Patient had a postpartum chill and her temperature went to 105. In view of the known infection, prontosil 10 cc q 4hr. and prontolyn gr.x q 4hr. were started at once and continued from 6/8 to 6/12, making in all a total of 140 cc of prontosil and 300 grs. of prontolyn. Daily transfusion of 175-250 cc of blood was given from 6/9 to 6/13. Within 24 hours after delivery, cyanosis was noted and gradually became more severe. Her tongue looked like that of a Chow dog. Her pulse was extremely rapid. On the 11th oxygen was administered without appreciable effect. On the 12th venesection was done withdrawing 200 cc of blood and replacing with some 250 cc of blood with some improvement. The medical service reported that her chest was negative but suggested testing for methemoglobin. On the 13th a specimen of blood showed methemoglobin with chocolate color to the blood. Prontolyn and prontosil were discontinued on the 12th because the temperature had dropped to near normal. On the 14th the blood showed no methemoglobin. Blood count on June 10th showed 3,230,000 rbc, 18,000 wbc and Hb 63%; on the 13th, 3,300,000 rbc, 22,000 wbc and Hb 68%. On the 19th a phlebitis of the right leg developed but this was not of an extensive type and the patient was discharged as well on 7/2/37.

The cause of the cyanosis is not really known. It is either methemoglobin or sulfhemoglobin or both, or as Marshall[1] has shown that the oxygen carrying power of the blood is but slightly changed, it may not be due to the iron pigments of the blood at all or only in part. Discombe[2] of London *warns against the use of sulfate in combination with sulfanilamide, also that while methemoglobin disappears quickly, sulfhemoglobin may not.* These iron pigments may not be the only cause of cyanosis. There probably is a connection with the sulfate given, hence sulfhemoglobinemia is the more logical cause although methemoglobin is also present. This patient had no sulfate but Feosol (ferrous sulfate), which is given routinely on the Obstetrical Service at the Maine General. She received 33 grs. before delivery and, after delivery until the twelfth of June, she received 42 grs., thereafter 9 grs. a day until discharged. This may be the explanation of the cyanosis we have noted developing in several other patients who have been given sulfanilamide. We stopped the treatment at once in those cases, but perhaps we should have stopped the Feosol.

References:

1. Marshall, E. K., and Walzl, E. M.: Cyanosis from Sulfanilamide, *John's Hopkins Hospital Bulletin*, August, 1937, P. 140.
2. Discombe, George: Sulfhemoglobinemia following Sulfanilamide Treatment, *Lancet*, 1: 626 (March, 1937).

The Eighty-Sixth Annual Session

The eighty-sixth annual session of the Maine Medical Association takes place at Bar Harbor, June 26th, 27th and 28th. I need not say anything about Bar Harbor and its many attractions. It is known as one of the beauty spots of the world, and is also the home of our popular president, Ralph Wakefield.

This year we are having two scientific sessions, as usual, and we have been so fortunate as to secure five speakers from out of the State who are authorities on the subject of which each will speak.

Monday afternoon will be a symposium on Acute Respiratory Infections and Complications.

Tuesday afternoon will be a symposium on Gynæcological and Obstetrical subjects, and a paper on Medical Publicity.

Sunday evening we propose to have an entertainment that both the gentlemen and ladies will enjoy.

Monday evening will be given over to the Cancer Problems, under the able direction of Dr. Little, and I understand that this is to be something extraordinary.

At the Tuesday evening banquet very good speakers are arranged for.

We have twenty-four conferences arranged for which take up all phases of Medicine, Surgery and the Specialties.

Steve Cobb promises me that there will be something doing in the way of entertainment all of the time.

Let's get behind this session and make it at least one of the best, if not the best, we have ever had.

Be sure and come Sunday afternoon and stay through because we really are trying to give a worthwhile entertainment Sunday night.

A detailed programme will be published in the May issue of the JOURNAL.

Come to Bar Harbor June 26th, 27th and 28th, and show our President that we are with him.

JOHN O. PIPER, M. D.,
Chairman Scientific Committee.

The President's Page

To the Members of the Maine Medical Association:

Having practiced in a summer resort for more than thirty years and having spent part of twenty winters in a Florida winter resort, I have had ample opportunity to observe the particular type of medical practice these places afford.

The individuals and families who frequent these resorts are necessarily well-to-do and are often the wealthiest people of the country.

It is not their wealth, however, that I wish to emphasize but the fact that they come from the most distinguished American families and are themselves the leaders in education, literature, the arts, music, diplomacy, finance, and the professions, to name a few of their accomplishments. By thoughtless people they have been called the "idle rich" but a very small percentage deserve this label. The majority are too intelligent, conscientious and aggressive to waste their time on trivialities.

With their sturdy background of the finest American manhood and womanhood, together with their culture, education and environment, they demand the best of the medical profession scientifically, morally and spiritually. The leaders of the medical profession serve them in their home cities and they expect the same high standard of professional skill in the resorts.

They are not prone to seek the latest fads and fantasies in medicine but demand sound and well-proved medical advice and conservative surgery.

The physician may count on their loyalty when once they are sure this is merited.

Aside from the financial consideration which is usually most satisfactory, the friendship, kindliness and association with these excellent people has been of the greatest pleasure and satisfaction.

Their friendship is genuine and their loyalty unquestioned.

Very regretfully and to the detriment of our American civilization these fine old families are gradually disintegrating and passing out of the picture.

Although the younger generations have inherited the strength of character and sterling virtues of their ancestors, the economic situation of the past few years has been so devastating that it has been impossible for them to "carry on."

Let us hope, however, that the future will be more kindly disposed.

Ralph W. Wakefield, M. D.

Editorial

Maternal Health

One of the major problems of today in preventive medicine is the reduction of maternal and neonatal mortality.

The report of the government's Technical Committee on Medical Care, recently submitted to the President of the United States, casts the principal need of the nation into two broad classes: "(1) needs in respect to maternity, infancy and childhood, which fall in a group by themselves, although intimately related to (2) needs in respect to health services precipitated by specific causes of sickness, disablement and death not directly associated with childbearing or with the hazards of early life."

At a conference on better care for mothers and babies, held in January, 1938, at Washington, D. C., and attended by 481 representatives of 86 national organizations, professional associations, health and social agencies, etc., the committee on findings reported as follows: "In 2,000,000 families in the United States in a single year the birth of a child is the most important event of the year. In more than 150,000 of these families the death of the mother or the newborn baby brings tragedy. Each year more than 14,000 women in the United States die from causes connected with childbirth, leaving at least 35,000 children motherless; more than 75,000 infants are stillborn; and more than 69,000 infants die during the first month of life. An uncounted number of other women are injured in health, and children are handicapped in growth and development as a result of conditions associated with maternity.

There has been little reduction in the maternal mortality rate during the 22 years for which records are available. Though the death rate from toxemias of pregnancy shows a tendency to decline, there is no comparable reduction in the death rate from infection or hemorrhage in the country at large. Committees of physicians in many parts of the country, after careful evaluation of the causes of death of individual mothers, are reporting that from one-half to two-thirds of maternal deaths are preventable. The stillbirth rate has apparently remained unchanged. There has been no decline in (infant) mortality on the first day after birth. More than one-half the deaths in the first month are deaths of premature infants. Thus the area in which the least ground has been gained in the saving of infant life is the mortality associated with the complications of pregnancy and labor and conditions of early infancy."

During the last two years, the Committee on Maternal Health of the Maine Medical Association has tried in every possible way to bring to the attention of Maine doctors the necessity for reduction of the maternal and neonatal mortality rate. It is possible that the program instituted with the assistance of the State Department of Health has been of some benefit, as during the last year there has been a reduction in the number of maternal deaths. Further progress along this line is necessary, however, and can only be obtained by the wholehearted coöperation of all who are doing obstetrics in this state.

The "refresher courses" given to several of the county societies have received commendation from those who made an effort to attend them, but in some instances the attendance has been far short of what it should be. We believe that everyone at all interested in the subject could benefit from the instruction and the excellent motion pictures which are shown in connection with it. The moving picture is unique as an aid to teaching surgery, in that it gives each spectator an opportunity to view operative procedures second only to that of the operator or his assistant, and the committee has done well to enlist this modern method of visual instruction in its campaign of education.

A review and analysis of all deaths in Maine which can be in any way ascribed to the puerperal state is being carried out by this committee in an effort to determine the most prevalent causes and to determine, if possible, some means to combat them. In cases where doubt exists as to the actual cause of death, questionnaires will be sent to the physicians reporting such cases, in order to clarify the diagnoses and place them under the proper classification. No criticism of the diagnosis or treatment by the attending physician is intended or implied by the sending of such a questionnaire; it is merely to aid the committee in its work; and no completed questionnaire will be made public or inspected by anyone except the committee. It is urged that any physician receiving such an inquiry from the Committee on Maternal Health will give it his prompt attention and answer all questions thereon to the best of his ability, before time has dimmed his memory of the case.

Activities of this sort in every state of the Union are conducted by men of unselfish motives, actuated only by the desire to improve the standards of obstetrics in their respective states. They welcome suggestions and criticism from any member of this association, and deserve the hearty support of all members.

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County News and Notes

Androscoggin

The regular meeting of the Androscoggin County Medical Society was held February 17, 1938.

The meeting was opened with the usual business discussion.

The main portion of the program was devoted to a lecture by Roland B. Moore, M. D., of Portland, on "Obstetrics," which was instructive, and well received. Following which movies were shown by Dr. R. L. Mitchell of Augusta on "The Conduct of Normal Labor," which were interesting.

The meeting was well attended, there being 31 members present.

Respectfully submitted,

A. E. Peters, M. D.,
Secretary.

The regular meeting of the Androscoggin County Medical Society was held March 17, 1938.

Meeting called to order by the president at 8.40 P. M.

Minutes of the last meeting were approved as read.

A letter from the State Secretary was read, reminding the members that dues are payable by April 1st to remain in good standing.

Dr. Greene presented a report of the Fee Schedule Committee with a table of fees drawn up. It was suggested by Dr. W. E. Webber that a copy of the schedule be sent to all the members for discussion at the next regular meeting. This was so voted.

Dr. C. W. Steele and Dr. V. H. Beeaker then presented papers on "Coronary Thrombosis" and "Extra-uterine Pregnancy" respectively. They were well prepared and delivered and yielded some interesting discussion.

Meeting adjourned at 10.35. There were 24 members present.

Respectfully submitted,

A. E. Peters, M. D.,
Secretary.

Cumberland

Portland Medical Club

The regular monthly meeting was held at the Columbia Hotel, Tuesday evening, March 1st, at 8.15 P. M. Nineteen members were present.

O. E. Haney, M. D., presented the paper of the evening, speaking on "The Diagnosis and Treatment of Some of the More Common Skin Diseases."

Alice Whittier,
Secretary.

Kennebec

A meeting of the Kennebec County Medical Association was held at the Augusta General Hospital, Augusta, Maine, Thursday, March 17, 1938.

Clinical Program at 5.00 P. M.:

1. "An Acute Abdominal Condition," V. T. Lathbury, M. D.
2. "A Case of Intestinal Obstruction with Diverticulitis," George A. Coombs, M. D.
3. "A Case of Scurvy and Rickets," N. B. Murphy, M. D.
4. "Eight Cases of Pneumonia," T. F. Fay, M. D.
5. "Generalized Carcinomatosis of Abdomen," "Glioma of Spinal Cord," Wm. J. O'Connor, M. D.

Dinner: 6.30 P. M.

Followed by a business meeting and scientific session. Minutes of the last meeting were read and approved.

The following were elected to membership:

Charles D. Cromwell, M. D., Fairfield; Wilson H. McWethy, M. D., Augusta; Joseph H. C. Michaud, M. D., Waterville; Edward T. Gary, M. D., Togus.

The following amendment to Chapter 1, Section 1, of the By-Laws was passed:

"Medical Officers of the United States Government medical services who are stationed in Kennebec County may become members on application, without registration in Maine, upon payment of dues."

A letter was read which was received from E. H. Risley, M. D., of Waterville, relative to the work of the Women's Field Army in the American Society for the Control of Cancer.

The address of the evening was presented by Edwin H. Place, M. D., Physician-in-Chief, South Department, Boston City Hospital, Boston, Mass., on "Contagious Diseases," which was amplified by lantern slides. This was very instructive and was followed by an informal discussion which brought out much valuable data relative to the present status of contagious diseases, especially as to treatment.

There were 42 members and guests present.

Respectfully submitted,

FREDERICK R. CARTER, M. D.,
Secretary.

Waldo

Officers elected at the annual meeting of the Waldo County Medical Society:

President, Foster C. Small, M. D., Belfast.

Vice-President, Eugene L. Stevens, M. D., Belfast.

Secretary-Treasurer, Raymond L. Torrey, M. D., Searsport.

Delegate to 1938 Annual Session of the Maine Medical Association, Foster C. Small, Belfast. Alternate, Eugene L. Stevens, Belfast.

Board of Censors: E. L. Stevens, C. H. Stevens, G. F. Miller.

RAYMOND L. TORREY, *Secretary.*

New Members

Cumberland

Carol Schwartz, M. D., Portland.
Harold Webb, M. D., Brunswick.

Hancock

Cyril E. Bousefield, M. D., Northeast Harbor.

Kennebec

Charles D. Cromwell, M. D., Fairfield.
Wilson H. McWethy, M. D., Augusta.
Joseph H. C. Michaud, M. D., Waterville.
Edward T. Gary, M. D., Togus.

Washington

James C. Bates, M. D., Calais.

100% County Societies

The County Societies, listed below, are hereby commended for 100 per cent payment of 1938 State dues:

Aroostook County Medical Society
Arthur T. Whitney, M. D., Secretary, Houlton

Franklin County Medical Society
James Reed, M. D., Secretary, Farmington

Hancock County Medical Society
Pliny A. Allen, M. D., Secretary, Bar Harbor

Penobscot County Medical Society
Forrest B. Ames, M. D., Secretary, Bangor

Piscataquis County Medical Society
Norman H. Nickerson, M. D., Secretary, Greenville

Sagadahoc County Medical Society
F. A. Winchenbach, M. D., Secretary, Bath

Washington County Medical Society
Oscar F. Larson, M. D., Secretary, Machias

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Coming Meetings

Cumberland

Cumberland County Medical Society, Harold V. Bickmore, M. D., Secretary, Portland.

The next meeting will be held Friday, April 22nd

Clinic: Maine General Hospital, 5.00 P. M.

Dinner: Eastland Hotel, 7.00 P. M.

Speaker: Henry R. Viets, M. D., Boston.

Subject: Acute Lymphocytic Meningitis and Other Virus Diseases of the Nervous System.

Connecticut State Medical Society, Hotel Griswold, Groton, June 1-2. Creighton Barker, M. D., 258 Church Street, New Haven, Secretary.

Rhode Island Medical Society, Providence, June 1-2. Guy W. Wells, M. D., Providence, Secretary.

American Medical Association, San Francisco, June 13-17. Olin West, M. D., 535 North Dearborn Street, Chicago, Secretary.

Maine Medical Association, The Malvern Hotel, Bar Harbor, June 26, 27, 28. Frederick R. Carter, M. D., 22 Arsenal Street, Portland, Secretary.

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Necrology

William Whitefield White, 1851-1938

Dr. William Whitefield White passed away on March 6, 1938, at his home on Court Street, Houlton, Maine, following a brief illness of pneumonia.

He was a native of White Cove, New Brunswick, but he spent the greater part of his life in Maine. In 1874 he was graduated from the University of Michigan and four years later completed his medical studies at the Jefferson Medical School.

Shortly after graduation he began practise in Pridgewater, Maine, where he remained for over forty years. Approximately twenty years ago he moved to Houlton, where he has since resided, and had continued practise until five years ago, when he was forced to retire because of failing vision.

Dr. White was always an active and interested member of his local Society and a number of years ago was awarded the medal of the Maine Medical Association for fifty years of continuous practise.

A man of Christian character and integrity, he was held in high esteem by fellow members of the medical profession and by a wide circle of friends and acquaintances.

He was a member of Central Lodge, I. O. O. F., of Bridgewater; of Aroostook Lodge, F. and A. M., of Mars Hill; of Aroostook R. A. Chapter and St. Aldemar Commandery, No. 17, K. T., of Houlton, and of Anah Temple, Mystic Shrine, of Bangor. He was also connected with the Church of the Good Shepherd and was active in its welfare, being a vestryman for over twelve years.

Dr. White was unmarried, his only surviving relatives being two brothers in Massachusetts.

Funeral services were held in Houlton under the auspices of the Masonic Lodge.

* * *

Notice

Fellowships Available to Members of the Maine Medical Association

Through the courtesy of the Bingham associates the following fellowships are available to members of the Maine Medical Association during the academic year 1938-39.

Courses in General Medicine will be given through the months of October, November, January, March and May. These are limited each month to six men.

Courses in Pediatrics will be given each month from October through May, each course being limited to two men.

A stipend of $250.00 per month is given men taking these courses.

Applications for these courses may be made through the State Secretary, Dr. Frederick R. Carter, 22 Arsenal Street, Portland, Maine.

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Book Reviews

"Pneumonia and Serum Therapy"

By Frederick T. Lord, M. D., Clinical Professor of Medicine, Emeritus, Harvard Medical School; Member of the Board of Consultation, Massachusetts General Hospital; and Member of Massachusetts Advisory Committee on Pneumonia, 1931-1935. Roderick Heffron, M. D., Field Director, Pneumonia Study and Service, Massachusetts Department of Public Health, 1931-1935. Published by The Commonwealth Fund, New York. Humphrey Milford, Oxford University Press, London. Price, $1.00.

The progress made in matters pertaining to the treatment of pneumococcus pneumonia with specific antiserum forced a complete revision of the work as published in 1936. Among the more important changes and additions are the inclusion of an outline of basic plans for comprehensive pneumonia control programs as community projects; further data on the incidence of types of pneumococci in the pneumonias; case fatality rates in the more common types of pneumococcus infection; and the results of antiserum treatment in a larger series of cases due to Type I and Type II pneumococci and in series of cases due to certain of the higher types.

Throughout the little work one senses the presence of what appears to be genuine enthusiasm for this new and apparently positively curative treatment of the pneumonias, especially Type I, with antiserum therapy. The exponents are able to show results which permit both doctor and patient to view pneumonia with more hope and greater courage in the future than they were able to do in the past. A form of therapy which can reduce case mortality by almost one-half has much to commend itself. It appears, however, that in order that antiserum may be applied most successfully earliest possible institution of treatments is absolutely necessary. In order to correctly treat the individual patient it is absolutely essential to correctly diagnose the type of pneumococci for each individual case by the Neufeld method as practiced by the Massachusetts Pneumonia Study.

Since there occur about 100,000 deaths from pneumonia a year in this country, and since every practicing physician is called upon to take care of patients suffering with pneumonia and may wish, or be called upon, to use this specific antiserum therapy, every doctor ought to own a copy of this, the latest work on pneumonia and serum therapy.

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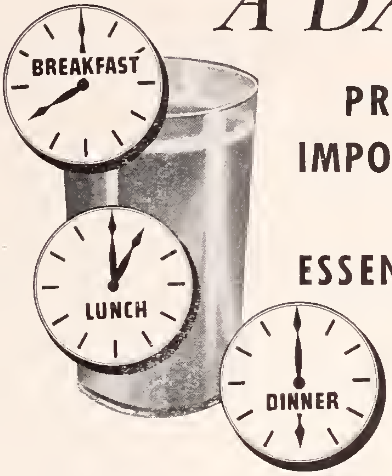

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"Emotional Adjustment in Marriage"

By Le Mon Clark, M. S., M. D., Assistant in Obstetrics and Gynecology, University of Illinois College of Medicine.

Published by the C. V. Mosby Co., St. Louis, 1937. Price, $3.00.

This remarkable little volume is dedicated to the normally built, normally feeling and heterosexually adjusted men and women of our own age, who have developed a healthy desire to become and remain happily satisfied husbands and wives of the present generation, and successful fathers and mothers for the next generation. It is a practicable guide to educate young men and women contemplating marriage in the art of that type of love which seeks and finds and is able to hold on to physical, emotional and mental satisfaction, contentment and happiness in monogamous marital relationship along scientifically correct, socially highly desirable, and morally fully acceptable theories and practices. The author adopts the long range view of the human family as a whole and shows how it can thrive best in our present day civilization. He highly recommends that the medical profession actively enter the field of pre-marital education, consultation and examination.

The author through this work radiates a wealth of positive enthusiasm. He presents rather new solutions to old problems. At an age so thoroughly flooded with life-negating pessimism as the present, he still possesses the courage to extol the life-confirming beauties of creative love as the most satisfying and happiness producing experience of monogamous marital relationship. This reviewer sincerely hopes to be forgiven by both author and readers for quoting a few lines from the many quotable pages of this great little book:

"Love as an emotional experience is most real. It has a vast influence for good or ill determined by the cultural background conditioning our response to the basic impulse. It is capable of the finest arborescence, although never separated from its root, the primary sensual stimulus. Although its manifestations may be different in the different sexes the physical enjoyment and spiritual exaltation should be as great for one as for the other. The fine and precious intimacy of association with one of the opposite sex is the basis of it. . . ." "Associated with love are many feelings: respect, admiration, fondness, affection, desire to help, longing to be helped, the wish for comfort and consolation, and the hope that these may be given to the other; in fact, the whole range of human emotions plays across the field of love like a kaleidoscope. . . ." "In an effort to enhance those values which contribute so much to marriage and to help young people to find the most complete satisfaction, physically and emotionally, centers for premarital advice and consultations have developed. This movement is almost world-wide. When one considers what is involved in a thorough and complete premarital consultation, it would seem to indicate that it may well develop into a very important medical specialty—something which takes elements from general medicine, obstetrics and gynecology, urology and psychiatry. The crying need is for the general practitioner to be equipped to deal with problems in this field."

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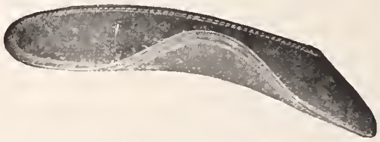

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BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

III. EXHAUSTING OR PREHEATING

● Modern canning procedures provide for the exclusion from the sealed container of air, and other gases present in raw food material, to the greatest possible degree.

In the sealed can, oxygen, in particular, is undesirable, whether it be released from food cells or be present in the form of entrapped air. If present in the sealed tin container, oxygen can react with the food and the interior of the can and directly affect the quality, nutritive value and merchantable life of the canned food. Other gases—for example, carbon dioxide produced by cellular respiration—should also be excluded as far as is practical. If present in large amounts, these gases may place undue strain on the container during the heat process to which canned foods are subjected.

In commercial canning practice, certain operations—specifically the blanch—may aid in elimination of gases from raw food tissues. However, main dependence is placed upon what are known as "exhausting" or "preheating" operations, not only to expel gases from raw foods, but also to exclude air from the can.

Briefly, the exhausting operation is accomplished by mechanically passing the open can containing the raw food through a so-called "exhaust box" in which hot water or steam is used to expand the food by heat and drive out air and other gases contained in the food and in the can. The times and temperatures used in commercial exhausting operations will naturally vary with the nature of the product (1).

After exhausting, the can is immediately permanently sealed, heat processed and cooled. During cooling, the contraction of the heated contents of the can creates the vacuum normally present in commercially canned foods.

With certain products, instead of exhausting as described above, the same effect is produced by preheating the food in kettles or similar devices; filling into the cans while still hot; and immediately sealing the containers. With still other products, an exhausting effect is produced by adding boiling water, syrup or brines to the food in the can. In some instances, exhausting is accomplished by mechanical rather than by thermal means. Specially designed sealing or "closing" machines are used to withdraw air and other gases by applying high vacuum to the can and immediately sealing on the cover.

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(1) Appertizing or The Art of Canning", A. W. Bitting, The Trade Pressroom, San Francisco, 1937.

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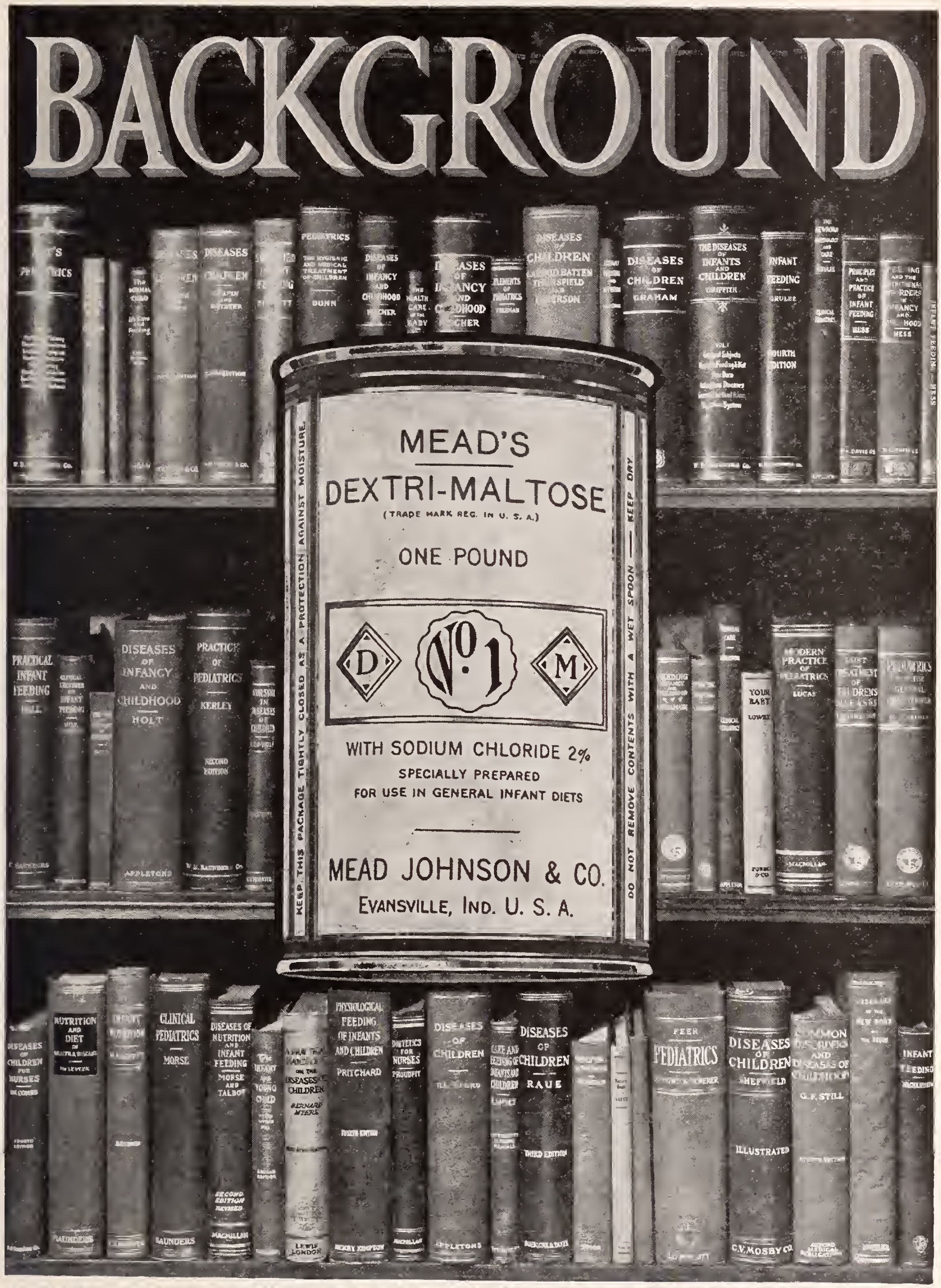
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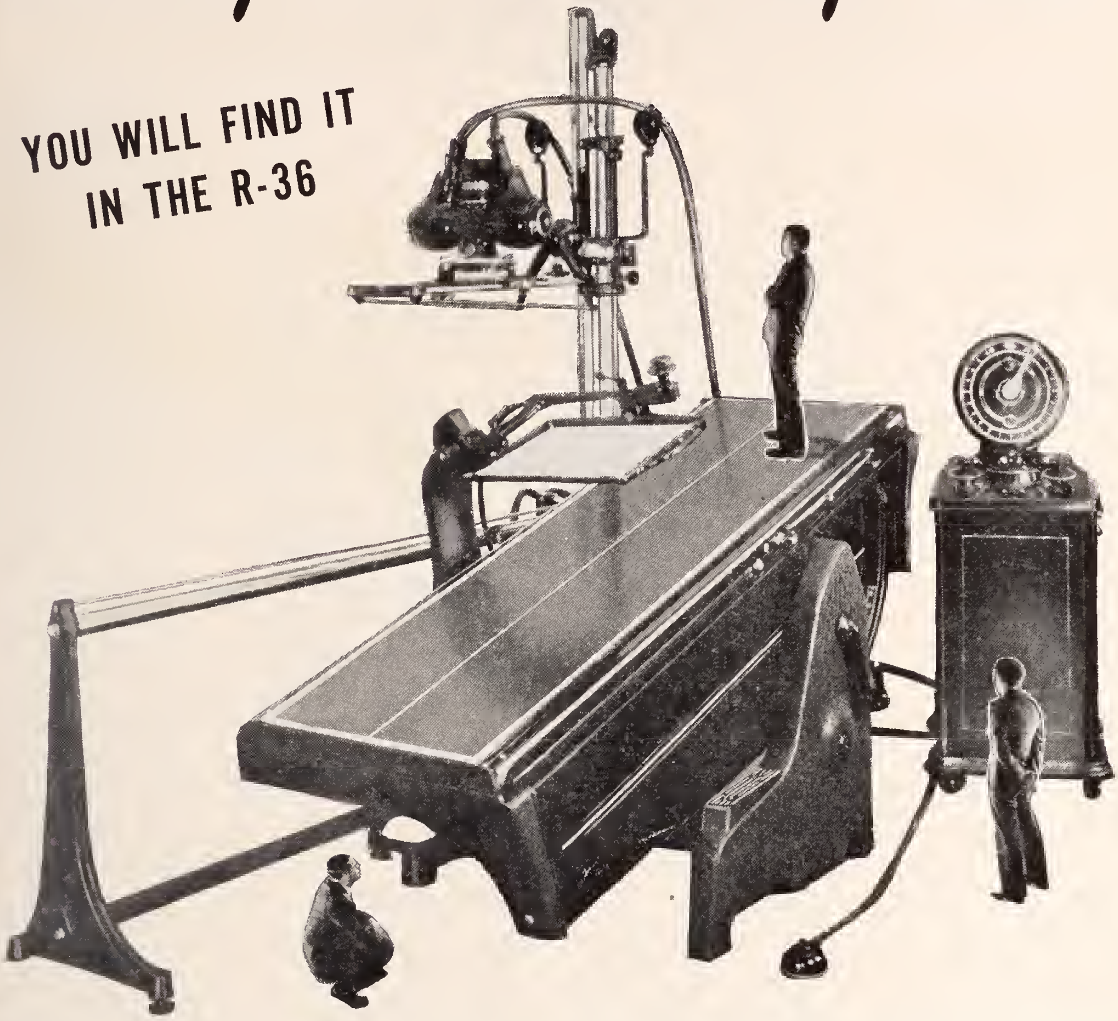

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Maine Medical Journal

The Official Organ of

The State and County Medical Societies

Vol. XXIX *Portland, Maine, May, 1938* *No. 5*

*Cancer of the Rectum**

By E. H. Risley, M. D., Waterville, Maine

Carcinoma of the rectum was formerly, and in fact up to quite recently, has been considered the most inoperable and hopeless of cancers. Today, cancer of the rectum can be looked upon as one of the most curable of cancers—if diagnosed and operated in its early stages.

No intestinal new growth with obscure symptoms is so easy of diagnosis as cancer of the rectum—and yet the diagnosis is missed in a very large percentage of cases, except in its well developed and many times terminal stages.

The symptoms which lead to a diagnosis of cancer of the rectum differ little, in the early stages, from those in other parts of the gastro-intestinal tract. Why, then, we may ask, do these cases come to the surgeon with a 50% inoperability, and have to be placed in the incurable and inoperable rather than in the curable class where they rightly belong?

Of necessity some blame must attach to the ignorance of the patient, who ascribes all bleeding or rectal discomfort to the presence of hemorrhoids and neglects to seek medical advice or examination.

The remainder of the blame, however, rests entirely with the physician first seeing the case. Failure to make a *routine rectal* examination in *all* cases complaining of *any* type of gastro-intestinal irregularity, causes him to miss the golden opportunity to make an early diagnosis and lead to an almost certain cure through early operation.

These facts cannot be stressed too strongly nor repeated too often. For the high percentage of inoperability can be laid only at the door of the general practitioner, and unless the profession at large recognizes these facts and makes an honest effort to rectify this fault, the surgeon will still be helpless in reducing the mortality and increasing the number of cures.

Many of the master surgeons of our country have been quoted as saying that among the most serious mistakes they have made in long years of practice, failure to make a rectal examination routinely was the most disastrous to the patient and humiliating to themselves.

Given a patient past middle life who exhibits symptoms of otherwise unexplained indigestion, diarrhœa or increasing constipation, loss of weight, increasing amounts of gas in the bowels, or perhaps the occurrence of blood or mucous in the stool, not explained by the presence of hemorrhoids; this patient should be strongly suspected of harboring cancer of some part of the gastro-intestinal tract, and a diligent search made for its exact location. If, in addition to the above symptoms, the patient has blood or pus in the stools, with rectal tenesmus or pelvic backache, a certain diagnosis of cancer can be made—provided ulcerative colitis is ruled out.

---

* Read before the Cumberland County Medical Society, December 10, 1937.

* Read before the Waldo County Medical Society, January 19, 1938.

The diagnosis of rectal cancer can be confirmed by digital, rectal examination in low situated growths, and by proctoscopy or sigmoidoscopy in growths at the rectosigmoid junction. It is rare that the barium enema X-ray is necessary unless we suspect a malignant degeneration of polypoid growths and wish to rule out the possible presence of other polypi higher in the colon. Also multiple malignancies of the colon do exist and should also be ruled out if possible.

About 90% of rectal new growths are situated on the anterior wall within easy reach of the examining finger and, therefore, furnish no adequate excuse for failure in their detection — provided routine rectal examinations are made. Those growths which are situated in the region of the recto-sigmoid junction may or may not be palpable, but they are practically always demonstrable by the 8-inch proctoscope. It is far more certain and far safer to make a diagnosis of, or to exclude, a rectal lesion by digital or proctoscopic examination than by the barium enema X-ray, which will, in a certain percentage of cases, miss the growth entirely; either because of its situation, or lack of enough irregularity to produce a diagnostic filling defect, or because of the redundancy of the colon which folds over at this point, obscuring the growth entirely.

Fortunate is the patient who has an early discovered cancer of the rectum. His chances of a cure are good, for, as stated above, carcinoma of the rectum—like early carcinoma of the stomach—is one of the most curable of cancers, if discovered and operated early.

This statement, we believe, is contrary to the generally accepted opinion, which looks upon all rectal malignancy as primarily hopeless and incurable. We would be remiss did we not emphasize the fact that this pessimistic attitude is an unfortunate and an unfounded one for the medical profession to take. Recent data from the large clinics of Jones, Miles, Rankin and others and even the results obtained by those of us who operate much smaller number of cases, proves very definitely that cancer of the rectum is no longer a disease to be feared as in the past

There do exist, however, certain very definite reasons why this disease was formerly an incurable one. These reasons have their basis in the fact that the early operations for cancer of the rectum were developed through a faulty approach and did not have as their essential requirement the eradication of all of the gland bearing areas of the pelvis. The old posterior approach of Kocher and Kraske were bloody and shocking operations with a necessarily high, almost prohibitive, mortality, and did not at all reach the pelvic lymphatic drainage areas, and hence were followed by rapid recurrences.

No chapter in surgery is more fascinating than the development of the various operative procedures for the cure of rectal cancer. The advent of the combined abdomino-perineal operation as gradually worked out by Coffey, Miles, Jones and Rankin has now placed cancer of the rectum in the curable class where it belongs and has given us a practically standardized operation which is gradually reducing the operative mortality and extending the cures well beyond the arbitrary five-year period.

It now remains for the general practitioner—the man first seeing the case—to increase the number of operable cases by keenness in history taking, by more complete physical examinations, and by the doing of routine rectal examinations. Only in this way can the still altogether too high inoperability be reduced to a point where the surgeon can be given a fair chance to cure cases referred to him for operation.

In estimating operability, one must take into consideration several important factors:

1. The general physical condition of the patient; and 2, the size, situation and adherence of the growth to surrounding structures and the presence or absence of demonstrable metastases.

1. The patient with marked anemia, loss of strength and weight, and who is suffering from the constant pain of rectal tenesmus, bleeding and purulent discharge, is probably in the inoperable class and has little to be offered except a palliative colostomy. (The advisability of which will be discussed later in this paper.) However, the size of the growth alone is not necessarily a contraindication to operation, provided the growth is not adherent or fixed to such surrounding structures as base of bladder, prostate, seminal vesicles or vaginal wall. Liver involvement, of course, makes the case in*cur*able, but not necessarily inoperable; for Jones and others have shown that even some patients with liver involvement, who have had the complete operation, have lived longer and in greater comfort than those who have been refused the complete operation on this account, and have had the palliative colostomy only.

2. If the growth is not adherent and the patient's general condition is satisfactory, he should be in the distinctly operable class, and if the growth has been discovered early, he should reasonably expect at least a five-year cure.

3. Too much stress cannot be laid upon adequate pre-operative preparation, for it is of the utmost importance. More attention should be paid to putting the patient in a suitable condition for operation, providing a suitable back log of resistance, than should be given to haste in getting rid of the carcinoma. The following efforts should be made: (A) Building up of general resistance; (B) Care of the genito-urinary tract; (C) Treatment of anemia; and (D) Treatment of the varying degrees of intestinal obstruction so commonly encountered in the less favorable cases.

Especial attention should be paid to the genito-urinary tract, for complications are very liable to occur here and cause a distressing and prolonged convalescence. It is very essential that kidney function be brought up to normal and especial attention be given to the elimination of urinary tract infections, well before operation is undertaken. The necessary trauma in the male to the undersurface of the bladder, the prostate and seminal vesicles, may be followed by serious cystitis, prostatitis and vesiculitis, epididymitis or ascending pyelitis, if proper treatment is not instituted long enough before operation to eliminate them. The necessity for post-operative bladder drainage has been pointedly emphasized by Barney (who recently presented an admirable paper on this subject before the New England Surgical Society).

Patients with marked anemia must have this corrected before undergoing the major operative work to which they must be submitted. Here, of course, transfusions are time-saving and essential.

In patients with any degree of obstruction, it is the wise surgeon who disregards, for the time being, the existence of the malignant growth and devotes his whole attention to overcoming the obstruction and its toxic effects. In acute obstructions it is probably wise to do a cecostomy at once, in order to tide the patient over this crisis. In the lesser degrees of obstruction one may be content to do the permanent colostomy first. With either of these openings one should attempt to irrigate the colon above and below the growth and to free it as much as possible from its toxic content before undertaking the major operation.

The question of pre-operative peritoneal immunization is one which we believe should be decided by the individual surgeon's experience. It has many advocates, yet Rankin, who has been one of its chief exponents in the past, has recently given it up on the ground that, in a comparable series of cases, the results were identical as to mortality, whether the vaccine was used or not. In the cases in which it was not used, he believes that the good results were obtained by giving more attention to preliminary decompression of the bowel and rehabilitation of the patient, which gave as good a peritoneal immunization as the vaccine.

Before discussing the operative procedure, emphasis should be placed upon the sometimes not fully appreciated fact that in all operations for *cure* of a rectal cancer, a *permanent* colostomy is an absolute requirement, and that preservation of the anal sphincter is no longer allowable if we have cure in mind.

The operative procedure which is recognized today as the minimum requirement for a cure, and as developed with slight variations by Coffey, Miles, Jones and Rankin, is a combined abdomino-perineal operation in one or two stages, according to the condition of the patient and the experience of the operator. The ideal is, of course, a one-stage operation, but this requires a large operative experience in this field, and a marked operative facility, and should probably not be undertaken by the occasional operator.

This complete operation offers the only chance to effect a cure. However, a preliminary colostomy and then a rapid posterior resection of the Lockheart-Mummery type is permissible—and many times advisable—in low situated growths and in poor risk subjects.

So far experience has shown that there is yet no place for radium or X-ray in *operable* cancer of the rectum, and, until very recently, painful reactions made radium treatment of inoperable cases almost prohibitive. However, recent developments in the technic of both radium and X-ray have given a more comfortable and hopeful outlook to the treatment of the inoperable case.

We would now like to speak in some detail regarding the after care of colostomies. This is a much discussed subject and opinions vary widely. However, it is generally conceded that a permanent colostomy is a vital necessity for a cure so that it is necessary that every consideration be given to the comfort and happiness of the patient who requires one.

So great is the natural aversion of most people to the idea of a colostomy that patients who often need one are extremely difficult to persuade to accept its necessity. They do not dread the care of the colostomy so much as they fear that its presence—and the possible odor—will shut them off from all normal social relations with friends and business associates. We have even heard physicians state that they would prefer death to a colostomy.

We are very sure that these apprehensions are mostly groundless and that the dread is founded on lack of real knowledge of how to properly care for such an artificial opening. Inquiry among patients who have lived with colostomies for many years shows that they lead happy, unrestricted lives, suffer very little inconvenience and go about socially, unhampered by dread of being obnoxious to their associates.

We have found, from a considerable experience, that the surest way to overcome this fear is to have prospective colostomy patients consult those of our former patients who have lived with a colostomy for a number of years. This is the quickest and most convincing way in which to overcome objections.

Physicians as well as patients offer many objections to a permanent stoma such as the uncertainty of its functioning at regular intervals, cumbersome apparatus, which limits physical activity, soiling of abdominal skin and offensive odor.

It is unfortunately true that the action of many colostomies *is* uncertain, and that they seem to resent regularity and prefer to discharge small fecal masses at frequent and irregular intervals. It is a fact that the opponents of colostomy do have some ground on which to base their objections. Therefore, anything the surgeon can do to make the care of a colostomy simpler and less objectionable for the patient is well worth our earnest effort. If we can also assure the patient that, with proper care, there will be no offensive odor and that he can go about his regular duties as before, we will have done much to relieve him of his dread of this often very necessary operation. The problem is *not* a difficult one.

There are three factors which make for success or failure in the adequate care of colostomies:

1. The proper making and placing of the colostomy;

2. Simplification of the colostomy apparatus; and

3. Regulation of bowel habit by carefully regulated diet.

The indications for the employment of a permanent colostomy are mainly in carcinoma of the rectum:

A. In all cases of radical removal.

B. In inoperable cases, for obstruction, or relief of pain and tenesmus.

C. For obstruction due to pelvic malignancy in women.

D. For relief of obstruction in diverticulitis or rectal stricture.

1. To be most effective and easiest to handle by the patient, a colostomy should be made, not in the left lower quadrant just inside the crest of the ileum, as has been the old-time practice, but in the median line about halfway between the symphasis and umbilicus. This situation is easiest for the patient to inspect, to reach and to attend to. It allows the patient to sit in the normal position on the toilet and have the fecal discharge drop into the toilet from the mid-line, in front, instead of having to be caught in a basin from the patient's left side, where soiling is bound to occur. If irrigation is necessary, it can be most easily done, while the patient is sitting on the toilet in the upright position.

To obtain a perfect opening of the midline single barrel type, the gut should protrude from the abdominal wall at least three inches at the time of the operation. This allows amply for post-operative swelling and its subsidence. After the swelling has gone down it is wise to cut the gut-end down to 1½ inches with the cautery. This leaves, at the end of three weeks, a perfect rose-bud protrusion rising above the abdominal wall.

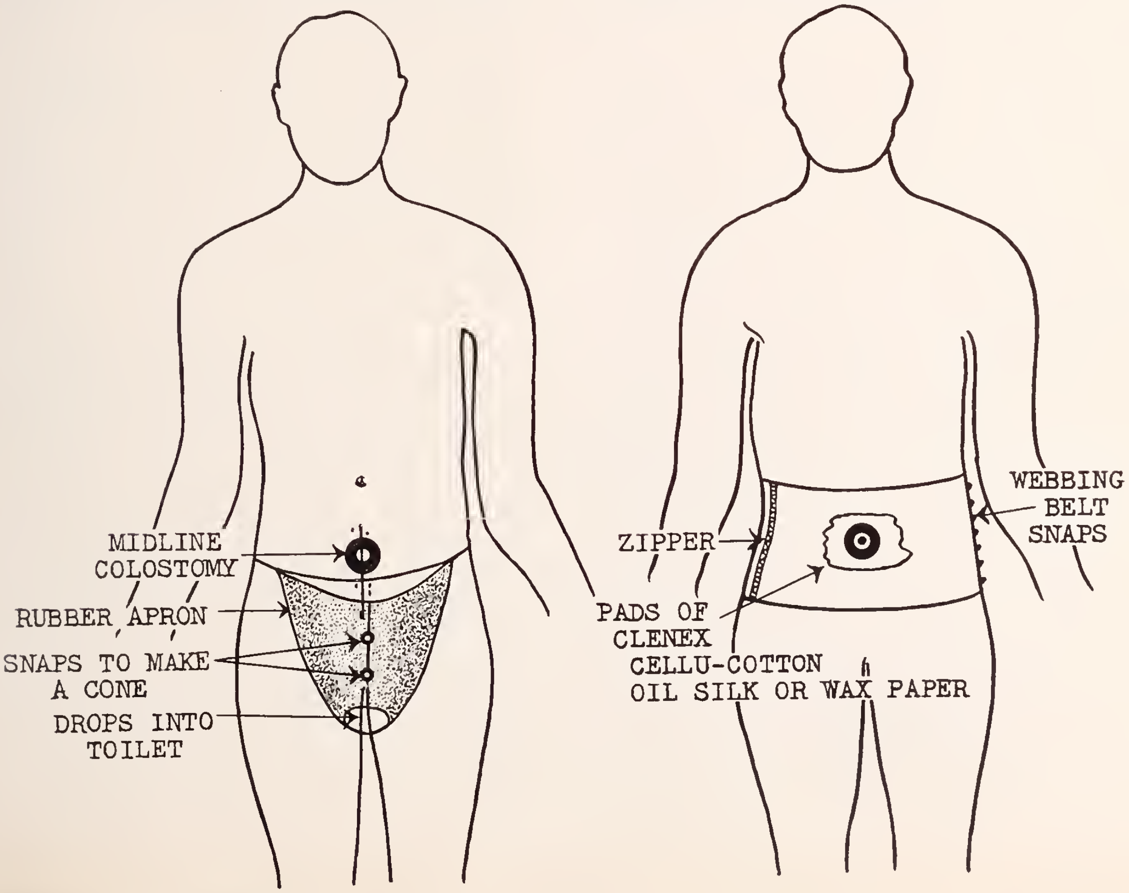
2. The colostomy apparatus.

This should be so simple that the patient can easily handle it himself.

The textbooks show pictures of the patient sitting on a stool with a pail on the floor in front of him, a standard with an irrigating can hung up beside him, a long irrigating tube held in one hand, a crescent basin in the other hand and a huge rubber apron draped about him and running down into the pail in front on the floor.

All of this cumbersome apparatus is absolutely unnecessary. The pail has to be emptied, the large rubber sheet washed and dried, and the basins and tubes cleaned and stored away after each daily use.

We have now solved this part of the difficulty by providing all of our colostomy patients, when they leave the hospital, with a small, especially designed rubber apron, which is tied securely around the waist, either just below the colostomy, or, if the stoma is protuberant enough, a small hole is cut in the upper part of the apron and fitted snugly over the stoma.



The sides of the apron are then buttoned together, forming a cone, which drops into the toilet. The patient then has his bowel movement into and through the apron without soiling himself or the seat.

If irrigation is necessary, this is done, not with a long, irrigating tube, but with a six-ounce bulb hand syringe fitted with a rubber catheter if desired. This prevents back-flow of jets of fluid which may spurt out with sufficient force to do much soiling of the surrounding neighborhood.

After the daily evacuation, and while up and dressed, the patient wears the following simple device, which, unlike any apparatus that I know of, takes up practically no room beneath the clothing and is not objectionable because of its bulk:

1. A snug, fitted cloth binder, made to fit the individual patient, and fastened either with a zipper or hooks for ease of removal or letting down on the side so as to change the inner pad.

2. A rounded pad of Kleenex or similar soft absorbent paper worn next to the skin and just thick enough to absorb some moisture.

3. Over this a slightly larger and thicker pad of cellulo-cotton.

4. And over these and snapped to the inner side of the cloth belt a sheet of oiled silk.

Should it be necessary at any time during the day to change the inner pad, the binder is released at the side, the inner pad is picked out and thrown into the toilet, replacing it with a fresh pad and pulling up the zipper.

With such a simple apparatus the patient can go into public without fear of carrying an offensive odor. If his bowels have moved before he leaves the house in the morning, there is very small chance that this pad will need changing during the day, provided he pays very strict attention to his diet.

3. *Diet.*

Care in diet and habit time are probably the two most important factors in keeping the colostomy patient comfortable. Our patients are put on the proper diet which is found to suit each individual patient, before they leave the hospital. This diet is one which will give one formed stool a day without the use of irrigation. It often requires some experimentation before the ideal diet is secured, but the patient soon learns to avoid foods which cause loose stools, because they are so much more comfortable with solid ones, which require the minimum of care. Habit time is even more important with colostomy patients than with the normal individual. Patients should go exactly at the same number of minutes after breakfast every day—not necessarily at the same hour—because that would not be a regular time.

Before they leave the hospital each patient is presented with one of our special rubber bibs and instructed in the simplest way of giving himself an enema, so that by the time he leaves the hospital he is well able to care for himself without assistance.

The apparatus worn does not make a pouch under the clothing. The small rubber colostomy apron can easily be washed and dried and carried in the ordinary ladies' pocketbook. This and the bulb syringe make an extremely small package which can be easily carried anywhere by the patient in travelling.

With the assurance of not being restricted in his activities, either business or social, with a small compact apparatus which takes up very little room in any bag and with complete dietary control of the bowels, patients need have no dread of colostomy and can lead happy, useful lives in spite of its presence.

Of surgical technic and personal cases I prefer not to speak. The former has had ample description by the masters of surgery and the relating of personal results adds nothing to such a discussion as I have presented.

May I conclude as follows:

1. Never let a patient with any otherwise unexplained gastro-intestinal symptom leave your office without a rectal examination, both digital and proctoscopic.

2. Spread the information among both physicians and patients that cancer of the rectum is a curable disease, and make it so yourself by doing rectal examinations on all of your patients.

3. Believe the testimony of my colostomy patients when they state that they do not mind their colostomies and lead happy and unrestricted lives with them.

*The Organization of a State Fracture Committee**

By Augustus Thorndike, Jr., M. D., Boston,
Secretary of the New England Committee on Fractures of the American College of Surgeons

Your Chairman has called this group together for its first organized meeting and has granted me the permission to suggest how this State may organize effectively. The aims of any state organization of this nature are manifold, among which are: (1) the care of the patient, (2) the education of the public and medical profession, (3) the simplification of later treatment in fractures, (4) the improvement of end-results, and (5) the standardization of records.

Traumatic surgery is playing an ever greater role in the practise of surgery in our own country due to an ever increasing number of industrial accidents, home accidents, and highway and playground accidents. Serious accidents due to the present-day mode of living are increasing yearly. Kennedy has estimated that between one and one and one-half million fractures occur annually.

The Executive Committee of the New England Fracture Committee of the American College of Surgeons have determined to devote this year's efforts toward (1) completion of membership in the Committee, (2) coöperation with the American Red Cross in its campaign for better treatment of highway accidents and the establishment of equipment and trained personnel in first-aid stations within the states and along the highways, (3) improving the fracture equipment and treatment in our hospitals, and (4) holding fracture meetings in each state this spring.

This meeting your Chairman has arranged accordingly. New Hampshire, Massachusetts and Vermont have already had theirs, and we trust that the material and discussions will be found profitable. The State of Maine Committee has been organized but is not as yet necessarily completed. Several states have added local daughter or satellite city or county committees which greatly benefit supervision and the solution of local problems in maintaining a high standard of fracture therapy. I suggest this to you either as a county committee where the number of hospitals and the population is sparse, or as a city committee where these factors and facilities are capable of warranting such a small geographical subdivision. Four such localized satellite or daughter committees have just been formed in Pennsylvania. It seems better to start any such State Committee small at first, and then, as conditions locally warrant, expand into smaller and more numerous local units or subdivisions.

One essential requisite is a good, active secretary who can and will keep in touch with the membership directly, suggest the holding of fracture symposia from time to time, and generally keep the parent Executive Committee of the New England group informed as to interest and progress. A good "esprit de corps" is essential.

All members of this Committee should obtain three pamphlets from the American College of Surgeons: (1) Transportation of the Injured, Kennedy; (2) Manual of Hospital Standardization of the American College of Surgeons; (3) Outline of Fracture Treatment of the American College of Surgeons. Armed with this information, each member should inform the superintendents, directors and trustees of his hospital of the activities of the State Committee and its aims, and even suggest to them that their own hospital does or does not qualify in equipment for the treatment of fractures (see page 49, Manual of Hospital Standardization).

In addition to the equipment, it is strongly suggested that the personnel of the hospital staff be combed and selected as qualified to form some responsible committee or actual fracture service that will be responsible for the supervision and treatment of fractures in that institution. Unfortunately some hospitals harbor jealousies almost insurmountable among members of the staff, but if the hospital reputation in the community is to be guarded, there must be coöperation and freedom of consultation service, especially in fracture therapy as accepted today.

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* Read before the Fracture Conference, Maine Medical Association Meeting, June 22, 1937.

This year our interest is focused on the American Red Cross campaign to improve the first-aid treatment of highway accidents. Many of us have seen relatively simple fractures made complicated or even compounded by the rough handling of such cases. The National Red Cross is establishing first-aid and emergency stations throughout the country. It is the pledge of this committee to aid and assist in the training of personnel, to put our shoulder to the wheel, and coöperate in every possible way. Ambulance services in some of our large cities and undertaker establishments in the less populated areas are doing most of the pick-up services in such accidents. Are these equipped with proper splints and trained personnel? The answer is to be found in our responsibility to see that they are. The State Police force in some states have their highway patrol already equipped for such service. Is that so here in this State?

In addition to this coöperation, it is our duty to keep the personnel of our own committee up-to-date in new and accepted methods of fracture therapy. It is impossible to emphasize this phase of our own responsibility to the patient, to the hospital, and to the community. The patient deserves it, our hospitals warrant it, and the community merits everything available. Post-graduate courses in fracture work are given in the larger medical schools each year, and every opportunity should be taken to refresh our own minds in fracture therapy.

In conclusion, it seems almost presumptuous to even suggest to this State Committee how it should organize and function. It is a local affair entirely and with no restrictions on what it may or may not do. The Executive Committee of the New England Regional Committee merely suggests in a supervisory manner, in order that it in turn may report progress to the General Fracture Committee of the American College of Surgeons. We welcome you into our group of organized fracture groups which at present number sixty-six in various parts of the United States and Canada. Those interested in further suggestions are referred to Dr. Scudder's report in the January (1937 and 1938) Bulletin of the American College of Surgeons.

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Clinicopathological Case Report[*]

An Intraperitoneal Rupture of the Bladder and Complete Rupture of the Urethra, with Bladder Floated Upward in Abdomen

By Harry L. Curtis, M. D., Portland, Maine
Senior Attending Urologist of Maine General Hospital

The patient, a boy ten years old, complaining only of pain in the lower abdomen, was admitted to the accident ward of the Maine General Hospital, October 5, 1937, at 10.30 P. M. His story was that in attempting to jump from the running board of a moving truck he slipped in the sand and struck his abdomen against the running board. However, following examination and noting the severe injuries received, it was felt that the wheel must have passed over him. Being unable to arise he was carried to the office of a local doctor, who, after giving him a "pill" (probably a sedative) and allowing him to rest for about thirty minutes, referred him to the hospital, a distance of sixty miles.

On physical examination the findings were as follows: Patient very pale, skin cold, pupils dilated but reacted to light, mucous membrane of lips very pale, lungs negative, heart not enlarged; rate regular but rapid, no murmurs. Abdomen spastic with tenderness most marked in lower part. There was a slight swelling just above the symphysis extending upward nearly to the umbilicus, this area was dull on percussion and extended laterally to the anterior superior spine of the ilium. Extremities showed no abrasions or tenderness. He was constantly moving his left leg but kept the right perfectly still. The only break in the skin was a small area about an inch across, between the shoulder blades, and there was no ecchymosis.

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[*] Presented at the Clinical Session of the Maine Medical Association, Portland, Maine, October 21, 1937.

Temperature 99F, pulse 132, respiration 30, blood pressure 80/60.

The mother reported that he had not voided since the accident, and had vomited twice.

Laboratory reports on the blood were: Hemoglobin 84%, red blood cells 4,050,000, white blood cells 14,500, with nearly a normal differential counts.

The patient was seen in the accident ward by a surgical interne and treated for shock. The interne, after examination, thought there was no fracture of the pelvis. As the patient kept continually trying to void, and because of suprapubic swelling and history of not voiding since accident, he ordered him catheterized. The orderly catheterized him without difficulty but got only a few drops of clear blood at first, later 5 cc. of urine. This was reported to the interne who called the Surgical Service and then asked me to see him in consultation. The patient was then transferred to the Urological Service with a tentative diagnosis of ruptured bladder.

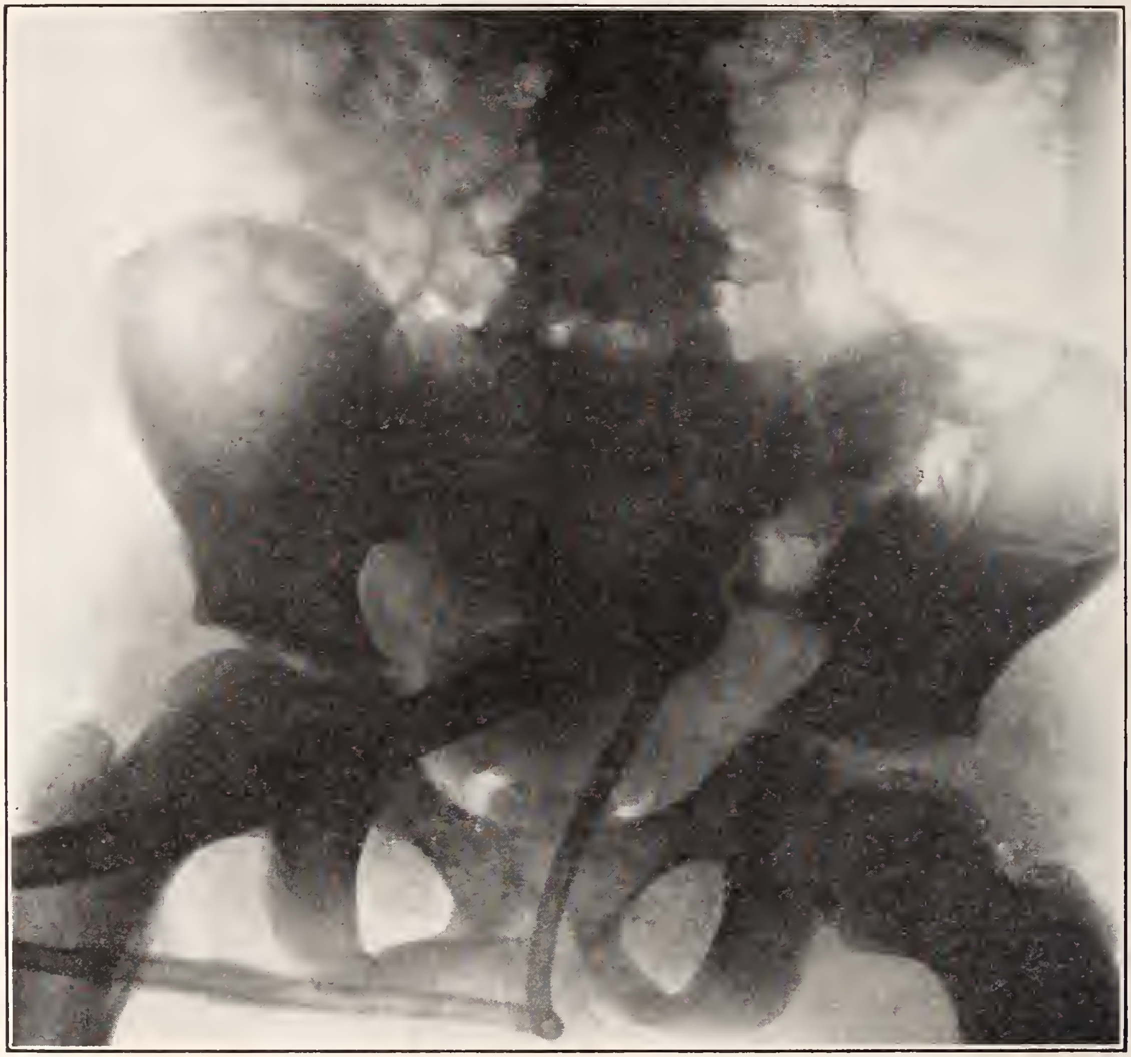
As I thought there was still a possibility of a fractured pelvis, an A. P. X-ray was taken which showed the symphysis to be separated over an inch, a fracture through the acetabulum and multiple fractures through the ilium and the junction with the sacrum. These fractures were all on the right side. The patient was again catheterized under rigid aseptic technique with the same findings. Then 150 cc. of sterile normal salt solution was injected through catheter and the same amount returned through catheter by gentle suprapubic pressure. Next diodrast was injected through a catheter and an X-ray taken. This showed a large amount of diodrast under the liver and between the bowel loops. This confirmed the tentative diagnosis of a ruptured bladder and that the urethral catheter extended into abdominal cavity. As the patient was not in condition for operation, he was given 500 cc. of 5% glucose solution and saline. Some improvement was noted in pulse and blood pressure. This was followed up by blood transfusion at 4.30 P. M., and again the following morning, each of 250 cc.

At 11.00 A. M., he reacted further: temperature 102°, pulse 150, respiration 40, blood pressure 104/60. Catheter drained approximately 300 cc. bloody urine. As he had reacted and was vomiting more with the abdomen slightly more tense I believed it time to operate. Consultation held.

At 4.00 P. M., gas ether administered and supra-pubic incision about five inches made. Muscles were of purplish color due to clotted blood between fibres. In the prevesical space and vesical space was found only blood clots. These removed, the retention catheter could be felt deep in pelvis with no tissue around it. On searching in upper part of the incision I found a thickened area of tissue which was pulled down and opened. This whole mass, which later proved to be the collapsed bladder, and its muscular wall was purplish in color but the mucous membrane was normal in appearance. On exploring the bladder the catheter could be felt and was extending upward through a hole in the posterior superior wall, 2½ inches in length. This was inverted through the incision and sutured with three rows of sutures then pushed back through the incision in bladder wall. Then a Brake prostatic hemostatic bag was inserted over retention catheter, the bag distended with sterile water, and by applying traction to the urethral catheter the bladder was pulled into position and sutured to abdominal wall after two Penrose drains were inserted, one in the prevesical space and one below the prostate area. Catheter held over Hamer anchor. Pezzar catheter inserted, bladder sutured and abdominal wall sutured with chromic catgut and silkworm and dressed. Then with second sterile operating set, patient redraped and field sterilized a right rectus incision was made; bowels found intact, cigarette drain placed in pelvis back of the bladder and another in right side of abdomen, allowing large amount of bloody urine to escape. Incision sutured and dressed.

On third day (post-operative) patient's temperature 100, pulse 120, respiration 30, blood pressure 100/60, urine output 2,000 cc. Taking fair amount of nourishment, bowels moving and expelling flatus. As improvement was satisfactory, orthopedic surgeons considered it the proper time to apply traction to the tibia, at proximal ends, and apply a body sling; this was considered the best way to treat the badly-fractured pelvis.

Prevesical drains were removed on the eighth day and abdominal drains on tenth day. Traction gradually loosened on hemostatic bag after first 48 hours.



Showing fractures of right Ilium. Symphysis has been pulled in place by traction. (Original film lost.)

He carried a rapid pulse, slight temperature, increased respiration, otherwise convalescence uneventful. Supra-pubic tube removed, also hemostatic bag, leaving urethral catheter to drain bladder. At the end of six weeks, traction was removed from lower extremities.

There is a small supra-pubic fistula in the bladder.

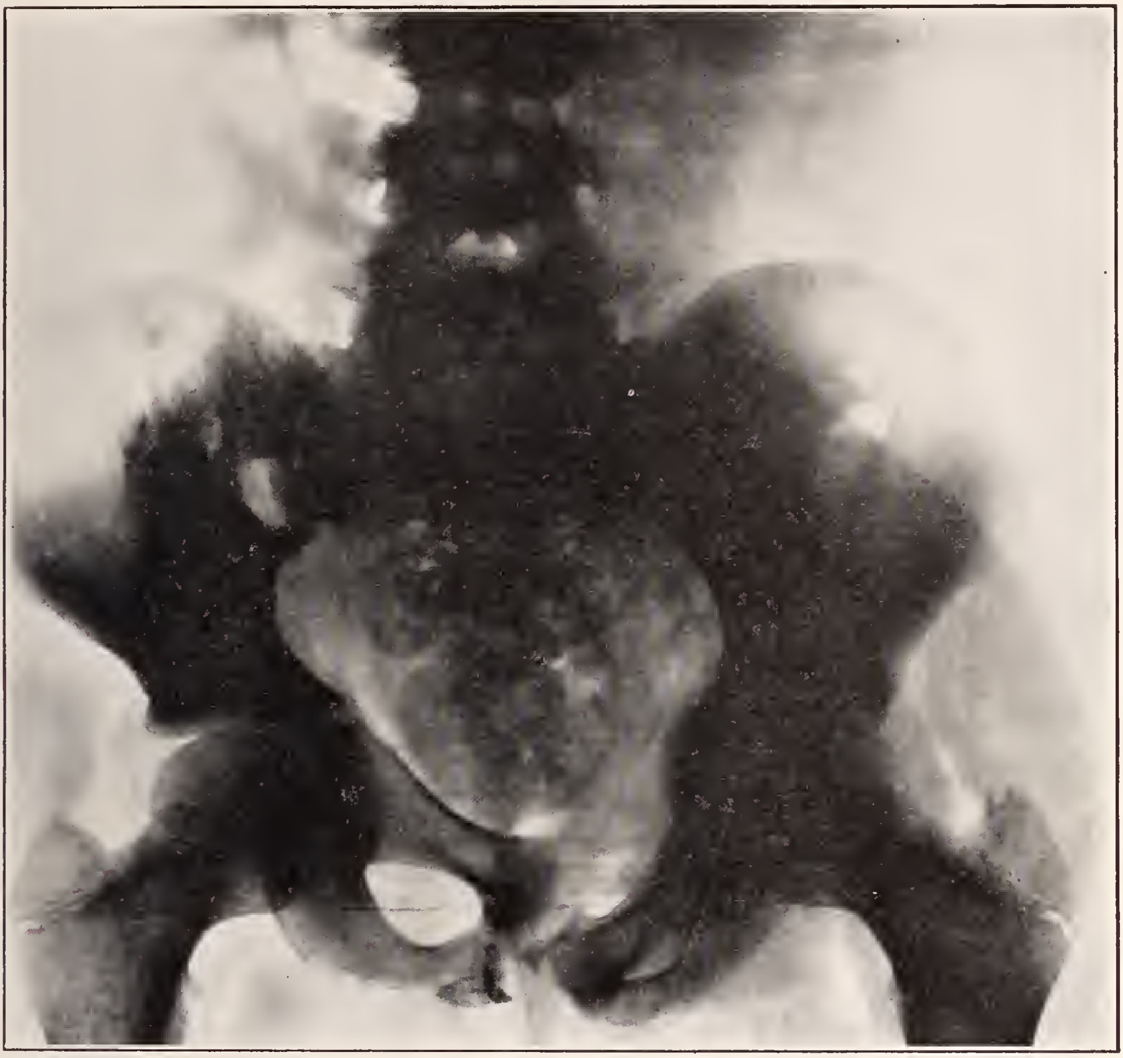
Prognosis as to life is good and that to control of micturition and sexual potency is uncertain, but the majority of these cases have done well.

Now at the end of the tenth week, patient is up in chair and walking about his room but still has the retention catheter because of a small supra-pubic fistula.

This case is of special interest as it is the only one on record at the Maine General Hospital with an intraperitoneal rupture of the bladder and complete rupture of urethra with the proximal and distal parts approximately five inches apart.

Since this case was reported the catheter has been removed and the patient has gained 14½ pounds in weight.

It is now eight weeks since the removal of the catheter and he has no signs of stricture and has a very good stream on voiding. He has not leaked through the supra-pubic fistula for eight days and has voided 400 cc. at one time. He dribbles some through the urethra when active, but I feel that he will have a perfect result. He walks without limping.

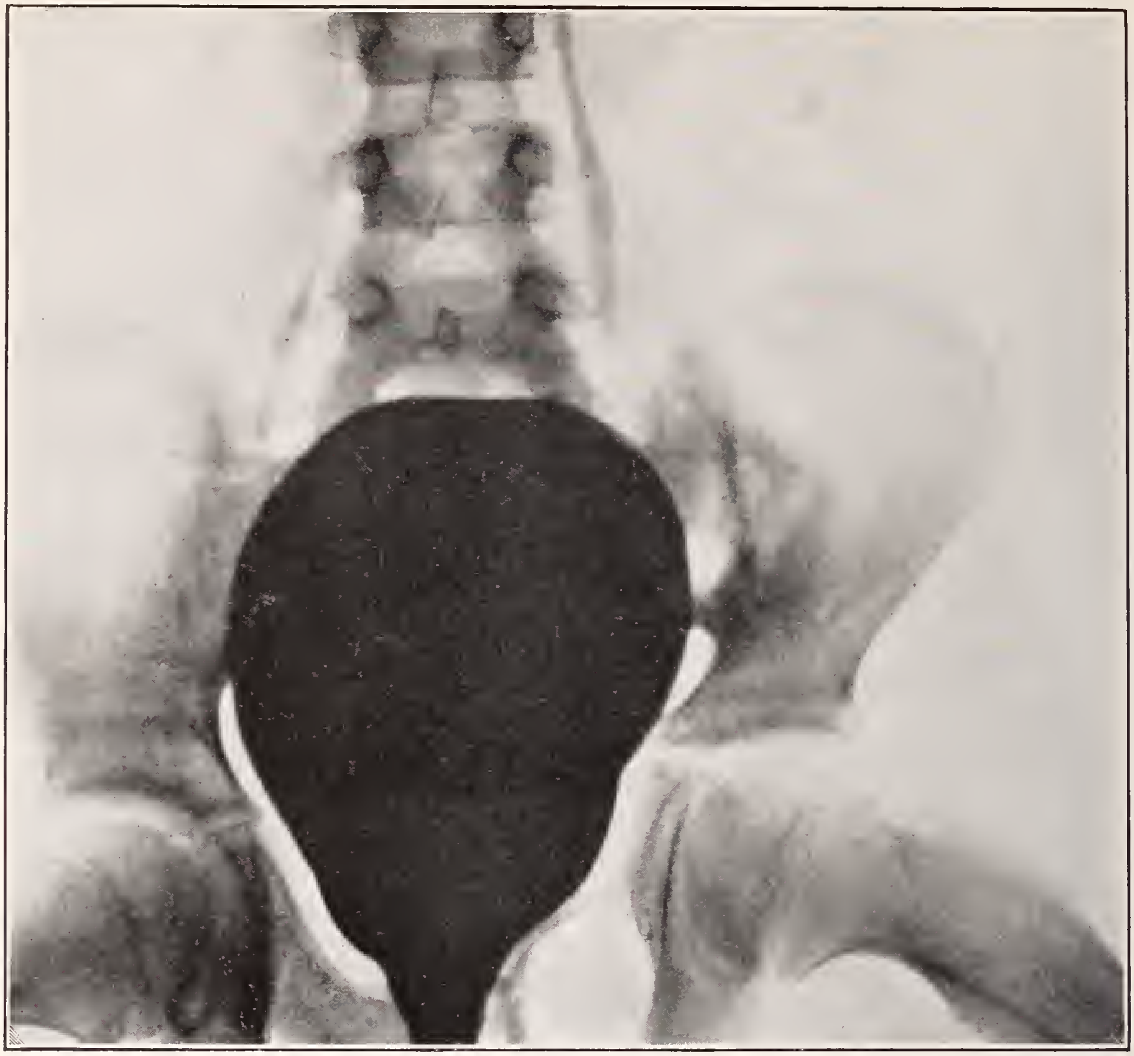


Showing final results of healed Ilium. Symphysis had slipped after he got up and around but the union was solid.

The patient has been cystoscoped and has had an intravenous pyelogram and cystogram done. The ruptured part of the bladder healed perfectly.

The symptoms, history and information received on catheterizing this boy are typical of these cases. Blood on catheterization with only a little urine. The desire to void but no results. The catheter was of great value for the information it gave, the amount of urine drained off, for retrograde injection of diodrast to clinch the diagnosis and give a thorough understanding of the situation before operation. (Intravenous iodine solutions are usually not of great value because of poor excreting in case of shock.) The catheter was also of value during the operation because it aided in locating the trouble as well as in applying the Brake Bag for traction.

Catheterization should be avoided in most



Cystogram of Bladder filled with thirteen ounces of sodium Iodide.

cases but is of value in this type rather than waiting for an increase in leucocystic counts, increase in temperature and pulse. The urine in a boy this age is usually sterile, and as he had already been catheterized I feel that the information received was well worth while. The injection of 150 cc. of sterile fluid in the bladder and the return of it has not been very satisfactory in most cases I have seen. Where the pelvis is fractured, complicated by rupture of the bladder and the patient in shock, I believe the chances are better if he is given fluid and transfusions until he reacts before operating, but in other cases it is often necessary to operate at once.

The Brake Bag (prostatic hemostatic bag) to apply traction to the bladder is my own idea and is far superior to a pezzar catheter and also superior to a catheter tied through the supra-pubic incision to some appliance as it gives closer approximation of the completely ruptured urethral parts. It also holds the lower part of the bladder distended and against the parts that they were torn away from.

The result, in this case which seemed almost beyond surgical possibility, patient not seen until seven hours following the accident with operation 23 hours later, is very gratifying.

The President's Page

To the Members of the Maine Medical Association:

The programme for the Annual Meeting of the Maine Medical Association published, in brief, in this number of the Journal speaks for itself. While, perhaps, it is an injustice to point to the work of any one committee, since all the committees have done excellent work this year, yet the burden for the success of our Annual Meeting falls most heavily on the shoulders of the Chairman of the Scientific Committee and his colleagues.

That the committee has given much thought, time and hard work to the task, a casual glance only of the programme will prove. Surely, there is no member so blasé or well informed that he will not find some points of interest, at least, in the programme.

I especially call your attention to the evening programmes:

Dr. Clarence C. Little, Director of the Jackson Memorial Cancer Laboratory, will have charge of the programme Monday evening, June 27th.

The principal speaker will be Dr. Fred Adair, of New York City, one of the foremost authorities on cancer in the world.

Dr. Little and his colleagues will present, by talks and lantern slides, the results of their research in cancer covering a period of more than ten years. Anyone interested in cancer (and who is not?) cannot afford to miss this symposium.

Dr. Frank H. Lahey of Boston, who will make the principal address of the evening at the Banquet, certainly needs no introduction to a Maine medical group. That his message will be well worth hearing is assured.

The report of the Councillors shows the County Societies are active and prosperous. As I have visited the various County Societies during the year I have been impressed with the large percentage of attendance, the excellence of the programmes and the enthusiasm of the membership.

I hope every member will take time to read these various reports in this issue of the Journal and in that way become acquainted with the work of the Association during this year and be able to appraise its value.

Ralph W. Wakefield, M. D.

Eighty-Sixth Annual Session

Program in Brief

SUNDAY, JUNE 26TH

4.30 P. M. First Meeting of the House of Delegates

8.00 P. M. Entertainment for the doctors and their wives

MONDAY, JUNE 27TH

9.30 to
12.00 A. M. Conferences

12.30 P. M. Luncheon

Tables will be reserved for reunions of alumni of Boston University, Johns Hopkins, Bowdoin, McGill and Harvard University Medical Schools.

2.00 to
4.45 P. M. Scientific Session

5.00 P. M. Election of President-elect

5.30 P. M. Second Meeting of the House of Delegates

7.00 P. M. Dinner

8.00 P. M. Cancer Symposium

1. Frank E. Adair, M. D., Memorial Hospital, New York City, Chairman of the Committee of Malignancy, American College of Surgeons: "Newer Additions to Diagnosis and Present Status of Therapy of Breast Tumors." 45 minutes
2. C. C. Little, M. D., Director, Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine: "Outline of the Biological Approach to the Experimental Study of Breast Tumors." 10 minutes
3. Miss Elizabeth Fekete, Research Associate, Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine: "Mammary Gland as a Site of Neoplastic Growth." 20 minutes
4. A. M. Cloudman, M. D., Research Associate, Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine: "Histopathology of Breast Tumors in Mice in Relation to Genetics." 20 minutes
5. J. J. Bittner, M. D., Research Associate, Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine: "Transmitted Influences affecting the Incidence of Breast Tumors in Mice." 20 minutes

TUESDAY, JUNE 28TH

9.30 to
12.00 A. M. Conferences

12.30 P. M. Past Presidents' and County Secretaries' Luncheons

2.00 to
5.00 P. M. Scientific Session

7.00 P. M. Banquet (dress informal)

Introduction of Visiting Delegates by President Ralph W. Wakefield, M. D.

Presentation of Fifty-Year Service Medals by Governor Lewis O. Barrows

Speakers:

Governor Lewis O. Barrows
Allan Craig, M. D., Bangor
Frank Lahey, M. D., Boston

Editorials

The Council on Pharmacy and Chemistry: A Professional Safeguard

One of the most valuable chemicals that has been presented to medicine for some time is sulfanilamide. Properly used under proper conditions it promises much and has done much. The deplorable tragedy, over seventy deaths occurred, resulting from the use of an "Elixir of Sulfanilamide," which was not an elixir but a solution of the drug in diethylene glycol was seemingly needless. Both of these substances have their proper uses but misfortune following their improper ones should neither be subjected to unfair criticism or made the means of profit by those who would attack their legitimate employment. The publicity given to sulfanilamide in the *Daily Press* afforded an opportunity for some to cash in "while the going was good": it was not neglected. That death and tragedy followed in the wake of such an effort is not a surprise. When the first reports of sulfanilamide and its value appeared in the professional journals early and emphatic warnings came from the Council on Pharmacy and Chemistry that due care must be employed in using the drug, caution and conservatism were enjoined and soon medical journals were printing reports and advice from competent clinical observers calling attention to clinical facts of great importance as to dosage, the signs and significance of danger signals even when the preparation was being used in doses deemed safe and proper.

According to a report from the Secretary of Agriculture, *Journal of the A. M. A.*, December 11, 1937, "the existing Food and Drugs Act *does not* require that new drugs be tested before they are put on the market." Regretable as it is that such is a fact it would seem that we can offer no excuse for prescribing any drug, chemical or combinations of the same concerning the lethal properties of which a doubt may exist. For many, many years the Council on Pharmacy and Chemistry has stood as an adviser to the profession and has made every possible effort to assist in the selection and use of safe products. The recommendations, *proposed* by the Secretary of Agriculture to be enacted, have long been the policy of the Council. It has had one object and only one. To protect the public and the profession from drugs or combinations of drugs that not only may be therapeutically useless but even harmful. Few physicians, even today, have the ability to distinguish real merit from the dangerous and absurd, not only in medicinal preparations, but in appliances offered for professional use. Not only are the claims of some manufacturers misleading, in some instances they are also inimical to the public welfare. Attempts to "go the sun one better" as a radiator of ultra violet rays are not few and unknown.

The latest tragedy to shock the public, as well as the profession, is another example of the great service rendered by the Council. Through the *Journal of the American Medical Association* it has advised against the use in medical practice of methods of treatment unstandardized, not under proper control and with no warrant for their employment beyond the financial interest of the makers or those employing the preparations. In 1935, we had the announcement from Kingston, Canada, well publicized in the newspapers, of a "treatment for cancer." Recognition of the claims of the "discoverer" were denied by the proper Canadian medical bodies and the *Journal of the A. M. A.* issued no uncertain warnings of the potential dangers in this uncontrolled and unproven method. The Orlando tragedy only too well emphasizes what can happen and what did happen. The "treatments" in Orlando were given by a duly licensed practitioner of medicine in the State of Florida. No warrant for the employment of either "ensol" or its American progeny can be advanced. Clinical and laboratory evidence is lacking entirely of any benefits in the treatment of malignancy. The coroner of Orlando absolved the physician from liability since he, the physician, did not have any control over the method of manufacture. Surely he must have had control of himself, but he testified that he had given several thousand injections and they probably were not all done gratuitously.

Most manufacturers recognize a greater responsibility to the public and profession than their legal ones. The House of Squibb well sums it up when it states: "The priceless ingredient of EVERY product is the honor and integrity of its makers."

Frederic Jay Cotton, M.D., F.A.C.S., 1869-1938

On April 14, 1938, the medical profession was shocked by the news of the sudden death of Dr. Cotton. His going is not only a severe loss to the profession as a surgeon of international reputation, but his death brings personal sadness to many of his colleagues all over this country and Canada. We who knew him well admire him for what he is—an inspired and inspiring leader in his profession, a true idealist with a remarkable genius for constructive action in his difficult field of specialized work, an enthusiast for his work, a man whose true sincerity and warm personality won the loyalty and devotion of countless friends among colleagues and patients.

No passive believer in theory, he was dynamic in his search for better methods in the difficult field of fracture surgery. Unselfish, his own preferment and personal ideas mattered not at all when a better way was advanced. Early and late he sought the better good, not satisfied with "what is" if end results did not sum up to what he hoped and worked for, exemplified in an article on "Hip Fractures" in the April issue of the *Journal of Bone and Joint Surgery.* On this important subject he had labored for many years. Characteristic of his saneness and conservatism he says: "We have moved ahead slowly and can say for the *first time* that a hip fracture *accurately* reduced by methods quoted can be further reduced into a valgus position with a vast advantage, and this can be done with precision."

In the field of the individual, his influence has been far-reaching as he touched the lives of many young men and stimulated them to high endeavor. To accomplish this is to achieve greatly. Generous in the praise of others and pleased greatly with the success that came to many of his former house officers he was always ready and willing to give of his advice and experience to many of his friends who found in him safe and sane counsel. Professional honors he accepted gratefully as one more way to advance. His contributions to surgical literature were many; phrased in his unique manner of writing, they drove home the truth and force of his suggestions too rarely seen. A talented artist and sculptor, he frequently exhibited sketches, water colors and bronzes noted for their individuality and personal expression.

Funeral services were held at the Emmanuel Church on Newbury Street, Boston, on the sixteenth of April. With the passing of Fred Cotton, the surgical world has lost a true leader and many, many of us a friend in all that the word implies.

Your Advertising Friends

We urge you to turn to the advertising pages and become acquainted with *your advertising friends.* Bear in mind the fact that each advertiser is carefully chosen, ethically sound, and sincerely your friend, in sympathy with the interests and activities of your Association. Visualize the care and thought that has been put into each insertion which brings to you its own individual message of importance. Take advantage of the opportunities you will find there to become *better* acquainted with your advertising friends and their products.

What you will find in this month's advertising pages is true of all issues of your JOURNAL. Advertisers are essentially a part of any publication but advertisers in a medical Journal must be *selected* in an effort to bring to you only approved products and equipment, therefore, do not think of your advertisers merely as a means of support. They bring to you each month last-minute developments which are of vital importance to you, a member of the medical profession. If you would be up to the minute, keep in step with your advertisers.

Remember, they give you *their* friendship and *their* support; give them *your* friendship and *your* support in return.

Councilor Reports

Report of Councilor, First District

Your Councilor for the First District has the honor to present the following report:

The Constitution and By-Laws of the Maine Medical Association, as adopted May, 1934, states the duties of the Councilors under Chapter VI, and in Section 2 of the chapter is written instructions for the Councilor as follows: "He shall visit each County in his District at least once a year . . . for inquiring into the condition of the profession and to keep in touch with the activities of and to aid in the betterment of the component societies of his District. He shall make an annual report of his work . . . . "

Your Councilor has visited the societies and has found the condition of the profession as normal as may be expected. Agitation exists when several members are gathered together over the practice of medicine by osteopaths. But nothing, so far as your Councilor knows, has been proposed to regulate it. In general, the societies in Cumberland and York are active, lively and prosperous.

The York County Medical Society, according to the records of the ever-active Secretary, Dr. Charles Kinghorn, have held regular quarterly meetings. In August Dr. Paul Hill was host at a clam bake of mountainous proportions held at Biddeford Pool on the grounds of the Hill summer cottage. Members from Cumberland County attended as guests. The weather, the food, the fellowship blended to produce a delightful occasion. In October, a meeting was held at the Tavern in Kennebunk. Dr. Ralph Wakefield addressed the meeting. The annual meeting was called in January at the Webber Hospital. Dr. W. H. Kelley of Sanford was elected President to succeed Dr. Edward C. Cook of York Village, and Dr. Kinghorn was re-elected Secretary. In April, a meeting and clinic was held at the Goodall Hospital in Sanford. The membership of 46 was 100% paid at the time this report was written. Three members have died and one new member has been elected.

In Cumberland County, the doctors have a Medical Society of 163 active members and seven honorary. October 21 and 22, 1937, the County Society in coöperation with the Maine General Hospital, the Maine Eye and Ear Infirmary, the Children's Hospital and St. Barnabas Hospital sponsored the Annual Clinical Session of the State Society. And on the evening of the 21st arranged a dinner at the Eastland Hotel and presented Milton C. Winternitz, M. D., Professor of Pathology at Yale Medical School who spoke on "The Pathology of Vascular Diseases." Meetings were held in November, January, March and April, with presentation of cases before clinics in the afternoons. At the annual meeting, E. H. Risley, M. D., of the State Society, was the speaker. Dr. Henry M. Swift was elected President and Dr. Harold Bickmore re-elected Secretary and Treasurer. The records, Dr. Bickmore states, show that nine members have died, two honorary and seven active.

Respectfully submitted,

Thomas A. Foster,
Councilor, First District.

Report of Councilor, Third District

As Councilor of the Third District, I submit the following report:

During the past year, Sagadahoc County Society has developed an increasing interest. The programs have been both interesting and instructive.

In August, Sagadahoc and Knox held a joint meeting. Doctors Roland Moore, T. A. Foster of Portland and R. M. Mitchell from the State Department of Welfare furnished the program.

Knox County Society held four meetings during the year, two of which were preceded by afternoon diagnostic clinics.

I feel the programs have been most helpful and the interest in the meetings is increasing.

Wm. Ellingwood, M. D.,
Councilor, Third District.

Report of Councilor, Fourth District

During the past year all County Societies in the Fourth District, Kennebec, Somerset and Waldo have been active.

Meetings have been held regularly, well attended, and many instructive clinics and papers have been presented to the members.

Members of the Fourth District are anticipating a fine session at Bar Harbor in June and will no doubt attend in appreciation of the interesting and instructive programs offered at that time.

Carl H. Stevens,
Councilor, Fourth District.

Report of Councilor, Fifth District

Hancock County Medical Society enjoyed its most vigorous year in 1937. The attendance at its more frequent meetings was uniformly good and the possibilities of interesting and instructive meetings in locations remote from medical surgical centers were amply proved.

Particular credit is due M. A. Torrey, M. D., of Ellsworth, who as Secretary of the Society provided good programmes and furnished the enthusiasm and inspiration which have been the missing ingredients for many years.

Several new members of outstanding qualifications were admitted during the year.

Despite the apparently adequate hospital facilities of this County, more than 400 of its residents were admitted to hospitals outside the County for treatment.

The Washington County Society met the usual three times during the year and in addition met once with their Canadian confreres at the Chipman Hospital in St. Stephen, N. B., for an instructive clinical meeting. During the current year this Society demonstrated its ability to settle a knotty and involved ethical question by direct and skillful methods.

Doctor Bennett has opened a new hospital in Lubec where he will have an opportunity to do the good work of which he is so capable, and this isolated community will have a long-recognized need fulfilled.

More than two hundred residents journeyed to hospitals outside this County in 1937 for treatment.

R. Bliss, M. D.,
Councilor, Fifth District.

Report of Councilor, Sixth District

As Councilor of the Sixth District, I submit the following report: The three Counties in this District, Aroostook, Penobscot and Piscataquis, have held their usual quota of meetings. I was present at two meetings of the Aroostook County Society, two joint meetings of the Penobscot and Piscataquis Counties, and a meeting in Bangor of the Penobscot Society. The attendance was very good and there was considerable discussion of the papers by the members present, and, seemingly, an increasing interest in Society affairs. I feel certain that the various Societies are becoming better informed and more interested in the proceedings of the Maine Medical Association. The papers at all meetings were interesting and enjoyed by the members as evidenced by the discussions which followed. I would like to urge every member of the Societies of this District to attend the Maine Medical meeting to be held in Bar Harbor in June, in order that they may obtain a better idea of what the Society is doing for the advancement of medicine; and, also, that they may get a better understanding of the viewpoints of members from all sections of the State.

Respectfully submitted,
P. L. B. Ebbett,
Councilor, Sixth District.

Committee Reports

Committee on Medical Education and Hospitals

To the Officers and Members of the Maine Medical Association:

The Committee on Medical Education and Hospitals submits the following report. The only matter which was referred to this Committee during the past year was relative to staff appointments in hospitals. Pursuant to the vote taken in the House of Delegates last June your Committee met with a similar committee from the Maine Hospital Association and adopted the following resolution:

"Staff appointments in hospitals shall be determined by a governing board of the hospital in coöperation with the active professional staff. It is advised that this be accomplished by consultation with a committee representing the active staff."

This resolution was unanimously accepted by the Maine Hospital Association. Your Committee advised and urged a similar action on the part of the Maine Medical Association.

Respectfully submitted,

Adam P. Leighton, M. D.
Frederick T. Hill, M. D.

Legislative Committee

There being no session of the Maine Legislature this year, the Legislative Committee has confined its activities to preparation for the Legislative session of 1939. At the last meeting of the House of Delegates at Belgrade Lakes in June, 1937, it was voted to present a Basic Science Law to the next session of the Maine Legislature to take the place of the present Medical Practice Act.

The Legislative Committee has given due consideration to this mandate from the House of Delegates.

It was soon found, however, that there is a wide divergence of opinion among the members of the Maine Medical Association as to the bill to be offered and how its enactment may best be accomplished. Apropos of this the Legislative Committee asked and obtained consent of the Council to enlarge itself to about fourteen members. These new members represent the different sections of the State and have all shades of opinion.

Before this report is published a meeting of the enlarged committee will have taken place and we earnestly hope that some definite medical legislation with an efficient method of offering the same to the Maine Legislature will have been accomplished. A report will be made to the House of Delegates at its next meeting.

Respectfully submitted,

Ralph W. Wakefield, M. D.,
Chairman.

Public Relations Committee

The Council referred to us a communication from the Pine Tree Society for Crippled Children, Bangor, Maine, requesting that the Maine Medical Society coördinate our efforts with them; they also requested our President to become a member of their Board of Directors.

We feel that while we are in sympathy with them in their work, the Medical Association should not affiliate with any lay organization.

Respectfully submitted,

G. R. Campbell,
H. C. Scribner,
W. S. Stinchfield.

Report of Cancer Committee, 1937-1938

Two meetings of the Cancer Committee have been held during the year, one during the annual session at Belgrade last June and the second in October at the clinical sessions in Portland.

At the Portland meeting two votes were

taken which will illustrate the major activities of the Committee for the year:

1. Approval was voted of the work of the Women's Field Army and the week of April 2, 1938, was approved for the educational campaign. At the writing of this report the results of the 1938 drive have not been tabulated. However, publicity has been excellent: the scope of the work has been much increased over that of 1937; and, in general, public interest has been appreciably greater. That more people of the State are becoming "Cancer Conscious" seems definitely true as a result of the splendid work of this lay group.

2. It was voted that each County Society be urged to devote at least one meeting during the year to the subject of cancer.

Early in November, 1937, a letter was sent to each of the County secretaries advising them of the above suggestion. Late in March a letter requesting information of Society proceedings was sent to each County secretary. Seven replies indicated that the subject of cancer, either in the form of discussion of the proposed drive of the Women's Field Army, or as prepared and delivered papers on the subject, had already been offered before the County groups.

At the meeting of the executive committee of the Women's Field Army, held in Portland in October, 1937, Dr. Edward H. Risley, of Waterville, was elected State Chairman. Dr. Risley, also a member of the Cancer Committee of the State Medical Association, proposed the collection of papers to form a symposium on the subject of cancer "suitable for presentation, from time to time, before various county societies." These papers were to cover the field as follows:

1. Recognition and treatment of precancerous lesions.

2. Modern advances in surgical handling of operable and inoperable cases.

3. The present status of X-ray therapy—pointing out especially the scope and limitations of this modality.

4. The same regarding radium.

5. Pathology, with special reference to grading and radio-sensitivity of the various types of malignancy and something about the dangers of biopsies.

A recent letter from Dr. Risley states that the papers have been collected and the whole symposium is available to any County group wishing to present the subject.

Reports from the various Tumor Clinics indicate that the volume of work is steadily increasing as educational measures progress. In all this work, the members of the Cancer Committee and the physicians of the State in general are expressing more and more interest and offering more and more time and service.

Forrest B. Ames, M. D.,
Chairman Cancer Committee,
Maine Medical Association.

Report of Nursing Committee

The following communication was referred to the Nursing Committee by the Council for their consideration:

"October 26, 1936.

F. T. Hill, M. D.

Dear Doctor:

Kindly take this matter up at your Council meeting.

My idea originates from Miss Katharine Shepard, Superintendent of the Household Nursing Association in Boston.

She has a school of instructions for attendant nurses to care for patients of moderate means.

The training course is 14 months. It consists of a six weeks' intensive domestic science course at the school under home conditions followed by 52 weeks of training in bedside nursing at a hospital. Then takes six months of supervised nursing in the homes of patients before receiving her certificate.

The requirements for admission to the school are: the age must be between 21 and 45, had a grammar school education, be in perfect health, have good standing in her community, like home life and be willing to sacrifice.

When approved the applicant pays a tuition fee of $50.00. This covers only about one-half of what it actually costs the school to train her. Public contributions and funds raised by activities make up the difference.

In addition the student will need $26.00 for uniforms and books. She will have no living expenses, as living is provided throughout the training. During the last ten months of her hospital training she is paid $6.00 a month.

After the year and six weeks of training she can find employment. For six months she works on private cases at $18.00 a week under the close supervision of the Association. Then she receives her diploma, raises her fee to $21.00 and is free to live and practice where she likes.

By having this to work on, I thought if some hospital in Maine could take up this proposition in training girls for attendant nurses, it would be a wonderful idea, as the majority of the doctors have families of moderate means who cannot afford a graduate nurse.

I trust something can be done about this; it will take time.

Signed: W. W. Hendee, M. D."

This school has been very successful, and its graduates are in great demand. The nursing education is given by several of the small hospitals of the State.

There is no question in this State but that something must be done to help the twenty- to thirty-dollar-a-week families. The public health nurses are a help where they are available. The experienced nurses are few and far between, and few are trained to properly care for the sick.

If some public-spirited organization in one of the larger cities could be encouraged to start this work, using the smaller hospitals as training schools, it would stand a fair chance of succeeding, and others might be added, or the small hospitals of themselves could offer courses, as we understand one is already doing with very encouraging success.

(Signed) Bertram L. Bryant,
Earle Richardson,
George A. Tibbetts.

Report of Advisory Committee on Syphilis Control

We have now twenty-six venereal disease clinics in the State. Recently there has been an increase in the reported cases, also of the contacts of these persons, and of delinquents, which the Health Bureau has been able to follow.

During the year, Dr. Benjamin Foster has visited six groups of physicians in different parts of the State for Round Table discussion of this problem, and Dr. Hunt has visited two groups in Aroostook County.

It is noted that there is a sharp increase in the number of Kahn and Hinton tests done at the State Laboratory.

Two physicians are about to take advantage of the month of observation work in treatment of syphilis in Massachusetts clinics. This is sponsored by the United States Public Health Service. It is plain that there is a great advantage for physicians in charge of clinics to attend these courses, and we are hoping that eventually all of our clinic physicians will have attended these courses.

This Committee believes that particular stress should be laid on case finding through blood tests during routine physical examinations, for expectant mothers and persons admitted to hospitals for any cause.

Benjamin B. Foster,
Chairman.

Committee on the Prevention and Amelioration of Deafness

While there is still much to be done in the field of prevention and amelioration of the hard of hearing, the chairman of this committee feels that at least a start has been made. A meeting of the committee was called in Portland during the clinical session of the Maine Medical Association. Preceding this in Chicago, it was the privilege of the chairman to be present at the meeting of the Committee on Deafness of the American Academy of Ophthalmology and Otolaryngology where some inspiration and some consolation was obtained. The magnitude of the work to be done and the inadequacy of the funds available were the outstanding points of the meeting.

The committee has been in correspondence with several well-known workers in this field, and plans have been laid for an instructive exhibit at the annual session in June. It is hoped that a post-graduate team and speakers in the summer sessions of educational institutions may later be arranged for.

Respectfully submitted,

HARRY BUTLER,
Chairman.

Committee on Graduate Education

To the Officers and Members of the Maine Medical Association:

The Committee on Graduate Education submits the following report:

Post-graduate education in medicine is of comparatively recent development in this country. Recognizing the lag which exists between its application and availability, the American Medical Association several years ago urged the development of post-graduate medicine. Considerable progress has been made in several states during the past few years. Last year at the meeting of the American Medical Association, a joint committee was formed to consider this matter of post-graduate education. During the past year, the President and Council of the Maine Medical Association appointed a Committee on Graduate Education.

The Committee has urged a more universal use of the present facilities available to members of our Association; the reading of contemporary medical literature, attendance and participation in meetings of County and State Societies, further development of the Hospital Staff Meetings, and, what is probably of most importance, attendance at meetings of the National Scientific Societies. The Committee has also endeavored to develop extension programs through the standing committees of the State Association, said programs to be made available for meetings of the constituent County Societies. Already such a program in Pediatrics and Obstetrics has proven its value, and we understand that a similar program is being developed by the Cancer Committee. Within the next year, similar programs should emanate from the other standing committees of the State Association.

We are extremely fortunate in Maine having, already available, fellowships in post-graduate education, furnished through the Commonwealth and the Bingham Funds. Your Committee has endeavored to coöperate with the directors of these two funds, acting in an advisory capacity, and stimulating the utilization of these fellowships where they would seem to do the most good. Increasing interest in these fellowships is attested by the greater demand for them, so that at present the supply does not equal the demand. These fellowships should be reserved, to a large extent, for those men so situated as to make it difficult or impossible for them to readily obtain post-graduate education independently.

Several of the states have developed rather elaborate extension programs in post-graduate education. In Michigan for years, a most comprehensive program has been carried on. While almost ideal, it is obviously too elaborate for our own State. In Massachusetts, a systematic course of lectures in various fundamental subjects is given in each councilor district, with a rotating faculty furnished by the State Association. It is proving most successful. It seems to your Committee that some such similar program can well be developed in Maine. A system of graduate lectures, basic in character, but bringing the latest in medicine, could be given in various centers of the State, perhaps in each councilor district, by different authorities on each subject. This can be done if sufficient interest be manifested on the part of our membership, and if the Association cares to underwrite the necessary expense. Your Committee suggests that this matter be considered by the house of delegates.

Your Committee also suggests that the name of this committee be changed to that on

Committee on Post-Graduate Education, in order to keep it in conformity with the standards set down by the various national boards. Post-graduate education is that branch of education which deals with the continuance of educational activities on the part of the practitioner after he has established himself in his profession, and it is this branch of education that your committee is concerned with.

Respectfully submitted,

FREDERICK T. HILL, M. D.,
JULIUS GOTTLIEB, M. D.,
NORMAN H. NICKERSON, M. D.,
FRANK H. JACKSON, M. D.,
E. EUGENE HOLT, JR., M. D.

Report of the Necrologist, 1937-1938

Maine Medical Association deceased members since June, 1937:

Abbott, Percy Hobbs, South Waterboro
Alden, Parker Eben, Thomaston
Bowers, John Wilder, Portland
Brown, Melvin James, Mars Hill
Bryant, Charles Sawyer, Millinocket
Caswell, Charles Oscar, Portland
Cunningham, Charles Hunter, Auburn
Fish, Edman Payson, Waterville
Gregory, Earle Pope, Fryeburg
Heald, Albert Parsons, Thomaston
Irish, Isaac Chase, Bowdoinham
Littlefield, James Gardner, South Paris
MacVane, Ernest F., Portland
Perkins, Joseph W., Wilton
Small, Hermon Wesley, Portland
Small, Richard Dresser, Portland
Spalding, James Alfred, Portland
Vosburgh, Stephen Earle, West Pownal
White, William Whitefield, Houlton.

Respectfully submitted,

FREDERICK R. CARTER,
Necrologist.

* * *

Maine Public Health Association

The Reason for the Early Diagnosis Campaign

Each year throughout the month of April, the Early Diagnosis Campaign is put on for the purpose of awakening people to the fact that we have over 300 persons die of Tuberculosis in Maine each year, and that Tuberculosis still remains the leading cause of death between the ages of 15 and 45, these being the most productive years of a person's life.

This is not a money-raising campaign, but purely an educational one. Since 1900 all facts indicate that Tuberculosis is a declining disease, but there are many factors which may suddenly increase the incidence of Tuberculosis as well as the death rate.

It was very clearly shown during the World War that the death rate of Tuberculosis jumped amazingly, especially in countries like Germany, where people could not get sufficient and proper diet.

We have found that the depression is a cause for the increase in Tuberculosis. In our own State of Maine, in 1931, the death rate per hundred thousand was 49; in 1932, 48; in 1933, 45; in 1934, 36; in 1935, 37.4, and in 1936 it had increased to over 40 deaths per hundred thousand.

There were 316 deaths in Maine in 1935 from tuberculosis, but in 1936 it had increased to 343. This seems to be due to the depression. Anything that affects the economic condition of people has a great tendency to lower the resistance to the disease because of insufficient and improper food.

It has been discovered that certain old-age groups present a great menace to young children, because the death rate from tuberculosis above 75 is very high and these old chronic cases are often living in families with their children and grandchildren. There is a shocking tuberculosis rate with infants under one year of age. 40% of these infants die of Tuberculous Meningitis.

This Campaign is put on by the Maine Public Health Association and its twenty affiliated associations. Its object is to uncover tuberculosis in the homes and in the schools.

12,843 pupils were tested in our Portland schools in the last four years, and there were found to be 1,364 reactors; 1,723 were X-rayed. There were 206 potential cases, 20 were active and the other 186 cases, by proper regulating and follow-up care by the school nurses, may be kept from developing into an adult active tuberculosis.

Editorial Comment:

The importance of the Campaign for Early Diagnosis of Tuberculosis cannot be overstated or over emphasized. The last sentence of this report bears abundant witness to the value of diagnosing these cases EARLY since proper regulation and aftercare means so much in the prevention of an active type of the disease. The Journal most heartily commends this movement and stands ready to lend all possible aid and support.

County News and Notes

Cumberland

Henry R. Viets, M. D., of Boston, spoke on *Acute Lymphocytic Meningitis and Other Virus Diseases of the Nervous System*, at a dinner meeting of the Cumberland County Medical Society, held at the Eastland Hotel, Friday, April 22nd, at 7.00 o'clock. Drs. E. A. Greco, E. H. Drake and T. A. Foster were appointed a Committee to arrange for an outing to be held sometime in August, to which the York County Medical Society will be invited.

Preceding the evening meeting a clinic was held at the Maine General Hospital. Cases were presented by Drs. George Tibbetts, E. H. Drake, E. R. Blaisdell, G. O. Cummings, J. R. Hamel and P. H. McCrum.

Harold V. Bickmore, M. D.,
Secretary.

Portland Medical Club

Resolutions

Whereas, death has come to our revered and long-time member, James A. Spalding, Bachelor of Arts, Doctor of Medicine, Doctor of Literature, and

Whereas, Dr. Spalding exhibited a constant interest and lively participation in the meetings of the Portland Medical Club for sixty years, and

Whereas, his companionship was treasured, his many medical papers highly valued and his philosophical reflections enjoyed and appreciated, and

Whereas, his absence from our company will be fresh in our minds always,

Be it resolved that the Portland Medical Club in meeting assembled on this fifth of April, 1938, record its irreparable loss in the death of Doctor Spalding, and

Be it further resolved that the Members cherish the sterling qualities and lofty aims exemplified in the life of our deceased companion, and

Be it further resolved that these resolutions be spread upon our records and a copy be published and forwarded to surviving members of the family.

Thomas A. Foster.

April 5, 1938.

Kennebec

A meeting of the Kennebec County Medical Association was held at the Gardiner General Hospital, Gardiner, Maine, Thursday, April 21, 1938.

Clinical Session at 5.00 P. M., which was presided over by Samuel H. Kagan, M. D., President of the Association.

1. (a) Papillary Cyst Adenoma Ovary; (b) Dermoid Cyst Ovary—G. W. Alexander, M. D.
2. Hypertrophy of the Prostate with Retention —F. Bull, M. D.
3. Meckel's Diverticulum—C. G. Farrell, M. D.
4. Successful Treatment of Two Fractures of Hip in patient age 92 years—A. B. Libby, M. D.
5. Esophageal Diverticulum — R. D. Simons, M. D.
6. Abdominal Tumor—I. E. McLaughlin, M. D.
7. Two Heart Cases—C. R. McLaughlin, M. D.
8. Internal Hodgkin's Disease—S. O. Clason, M. D.

Dinner at 6.30 P. M.

Followed by a business meeting. Minutes of the last meeting were read and approved.

Edwin W. Harlow, M. D., of Waterville, was admitted to membership by transfer from the Somerset County Medical Association.

Application for membership of Burton W. Trask, M. D., of Augusta, was received and referred to the Board of Councillors.

A letter was read from Edwin H. Place, M. D., of Boston, who spoke at the previous meeting, making a few minor corrections in his paper.

Another letter was read from Herbert R. Kobes, M. D., of Augusta, relative to the County Association sponsoring a clinic in May. It was voted that the Association sponsor an orthopedic clinic Thursday, May 26, 1938, not earlier than 4.30 P. M.

Ralph W. Wakefield, M. D., President of the Maine Medical Association, was present and spoke briefly relative to the annual meeting to be held at Bar Harbor, Maine.

The address of the evening was given by Samuel H. Proger, M. D., Assistant Professor of Medicine at Tufts College Medical School and Medical Director of the Diagnostic Hospital, New England Medical Center. Subject: *The Heart After Forty*. Dr. Proger stated that very few people beyond middle age are free of coronary disease or symptoms, yet show no physical signs. He divided coronary diseases into four headings:

1. Latent Group.
2. Cardiac Pain.
    (a) Angina Pectoris.
    (b) Coronary Thrombosis.
3. Congestive Heart Failure.
4. Cardiac Asthma.

He stated that attention paid to this latent type of coronary disease can do much in keeping these cases from breaking down and early attention to senile cardiac conditions can be greatly benefited. He gave a valuable and practical talk on coronary disease of the senile group, discussing the different groups from the viewpoint of diagnosis, prognosis and treatment. The members derived much valuable information as to the best methods of treatment in these heart conditions.

There were 42 members and guests present.

Frederick R. Carter,
Secretary.

Knox

The annual meeting of the Knox County Medical Society was held on February 14, 1938, at Rockland, Me. The following officers were reelected:

President, A. F. Green, Camden.

Vice-President, Howard Apollonio, Camden.

Secretary-Treasurer, C. B. Popplestone, Rockland.

Delegates to the 1938 Annual Session of the Maine Medical Association, C. H. Jameson, C. B. Popplestone.

Alternates, A. F. Fuller, Wm. Ellingwood.

Board of Censors, Neil A. Fogg, Robert W. Belknap, C. H. Jameson.

Penobscot

On February 15th the regular meeting of the Penobscot County Medical Association was held with Dr. Allan Woodcock of Bangor and Dr. Samuel S. Silsby of Bangor presenting an Orthopedic Clinic. The evening meeting was given over to discussion of Association problems, including the matter of mal-practice suits and medical liability insurance.

On March 15th the regular meeting of the Penobscot County Medical Association was held with Dr. H. H. Faxon, Assistant Surgeon of the Mass. General Hospital, as the guest. Ward walks were conducted by Doctor Faxon in the morning at the Eastern Maine General Hospital and a clinical session presided over by Doctor Faxon in the afternoon. In the evening Doctor Faxon delivered a paper on the subject of "Vascular Diseases." Dr. Ralph Wakefield, President of the State Association, and Dr. P. B. L. Ebbett of Houlton, Counsilor for our district, were present and talked on the general subject of medical liability insurance.

Forrest B. Ames, M. D.,
Secretary Penobscot County Medical Association.

The regular monthly meeting of the Penobscot County Medical Association was held in conjunction with clinics at the Eastern Maine General Hospital on Monday and Tuesday, April 18th and 19th. The following program was presented:

Monday, 9.00 A. M. and 3.30 P. M. Medical clinics at the Eastern Maine General Hospital.

6.30 P. M. Dinner at the Bangor House, with Round Table discussion on Rheumatic Infection, Dr. William B. Breed, Boston.

Tuesday, 9.00 A. M. and 3.30 P. M. Surgical clinics at the Eastern Maine General Hospital.

7.00 P. M. Business meeting of the Association at the Hospital.

7.45 P. M. Dinner at Hospital.

The paper of the evening was presented by Dr. Arthur W. Allen, the subject being *Peptic Ulcer.*

Forrest B. Ames, M. D., *Secretary,*
Penobscot County Medical Society.

New Members

Cumberland

Paul Marston, M. D., Kezar Falls.
Raymond Tougas, M. D., Brunswick.

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Coming Meetings

Waldo

Waldo County Medical Society, Raymond L. Torrey, M. D., Searsport, Secretary.

The Waldo County Medical Society will meet at the Windsor Hotel, Belfast, Thursday evening, May 26, 1938. Dinner at 6.30, followed by business meeting. Harold E. Pressey, M. D., of Bangor, will present a paper on *Some Physiotherapy Methods in Modern Medicine.*

Connecticut State Medical Society, Hotel Griswold, Groton, June 1-2. Creighton Barker, M. D., 258 Church Street, New Haven, Secretary.

Rhode Island Medical Society, Providence, June 1-2. Guy W. Wells, M. D., Providence, Secretary.

American Medical Association, San Francisco, June 13-17. Olin West, M. D., 535 North Dearborn Street, Chicago, Secretary.

Maine Medical Association, The Malvern Hotel, Bar Harbor, June 26, 27, 28. Frederick R. Carter, M. D., 22 Arsenal Street, Portland, Secretary.

Notice

Hospital Day

Since the idea of a National Hospital Day was instituted back in the early twenties by our beloved Mathew O. Foley, there has been a growing interest throughout the hospital field. Each year has found a larger number of hospitals taking part in the celebration and opening their doors to the public. This effort, perhaps as much as any other one factor, has served to educate the public in modern hospital procedure and facilities. Then, too, Hospital Day programs, as they have been carried on in many institutions, have been arranged so as to educate the public in sickness prevention, health habits, and simple methods of home treatment.

If all the hospitals in our land put forth a concerted effort to enlighten the public that day in that which the hospital is able to do for them, it would be a mighty factor in breaking down any prejudice or misunderstanding that might be existing in their communities.

Paul R. Cone, *Chairman,*
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Single room with bath	$8.00 per day
Double room with bath and single beds, each person	$8.00 per day
Two double connecting rooms with bath and single beds, four persons, each	$7.00 per day
Single room with running hot and cold water	$7.00 per day
Double room with running hot and cold water, with single beds, each person	$6.00 per day
Cottage	$8.00 per person

Charges for meals to one not having a room:

Breakfast	$1.00	Dinner	$2.50
Luncheon	$2.00	Banquet	$2.50

The daily rate includes the banquet, providing guests remain one full day.

Belmont Hotel

The management of the Belmont Hotel, Bar Harbor, Maine, has been pleased to quote the following rates for members of the Association in attendance at the annual meeting:

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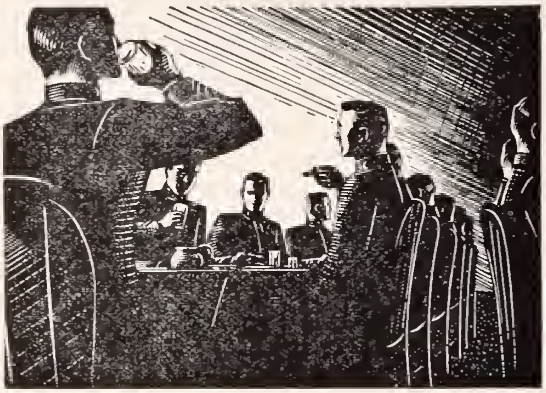

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Book Reviews

"Hernia: Anatomy, Etiology, Symptoms, Diagnosis, Differential Diagnosis, Prognosis, and the Operative and Injection Treatment"

By Leigh F. Watson, M. D., member of Attending Staff of California Lutheran Hospital and Methodist Hospital of Southern California, Los Angeles. Published by the C. V. Mosby Co., St. Louis, 1938, Second Edition. Price, $7.50.

This most excellent work on hernia contains in this revised edition several chapters on the modern injection methods of treatment of certain types of reducible hernia. This form of treatment has been rather widely adopted by many industrial corporations, insurance companies, state industrial commissions, etc. The subject matter has been brought up to date. The author's experience seems to have firmly convinced him of the great value and the far-reaching economic importance to industry of this, the injection method, for the treatment of selected cases of reducible hernia.

The operative techniques are profusely illustrated with two hundred and eighty-one fine illustrations. Every step in the entire procedure in the care and treatment of each type is outlined in clear style and in full detail. The silk technique of the original Halsted operation, as practiced nowadays, is fully described. The medico-legal chapter was rewritten to embrace the latest opinions and rulings of insurance carriers and state industrial commissions. The problem of hernia is well presented in all its aspects from etiology through diagnosis and treatment to legal adjustment.

Certainly this is a book which belongs to the equipment of every practitioner who is called upon to treat hernia of any type at any age whether best results are to be worked for by surgical or injection methods of treatment.

"Men Past Forty"

By A. F. Niemoeller, A. B., M. A., B. S. Author of "American Encyclopedia of Sex," etc. With a foreword by Winfield Scott Pugh, B. S., M. D. Published by Harvest House, New York, 1938. Price, $2.00.

According to the foreword "*Men Past Forty* is an admirable work on impotence and rejuvenation. It explains what impotence is, describes different kinds. It tells what may be done in cases amenable to treatment and how you may help yourself. In regard to treatment, about everything that has ever been heard of is mentioned in this book."

It appears that the author of this little book draws his inspiration from the notion that "much too often does the age of forty mark the end, or at least the beginning of the end, of a man's sexual activity and potency." He then goes on to tell, with the aid of rather poorly selected illustrations, what has been done about it. He promises much but, dealing in 140 pages with such a great variety of possible causes of apparent or real physical, emotional and mental disharmony, maladjustment, discontent, unhappiness, etc., that may develop in the sphere of the sexual life of modern man, nothing new of any lasting therapeutic benefit is presented to the reader.

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Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3
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Volume Twenty-nine June, 1938 Number Six

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Communicate at once with the Marks Printing House, Portland, Maine, if reprints of articles are wanted.

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The energy supply should be in the form which is easily digested, not readily fermented and which does not affect the appetite for other foods. Karo meets all these requirements.

Infant feeding practice is primarily the concern of the physician, therefore, Karo for infant feeding is advertised to the Medical Profession exclusively.

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Convenient Calculator of Infant Feeding Formulas; accurate, instructive, helpful. On receipt of Physician's prescription blank, giving name and address, the Calculator will be forwarded. Write Corn Products Sales Co., Dept. SJ-6, 17 Battery Place, New York, N. Y.

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The patient who is unable to exercise or adhere to a suitable diet will appreciate the aid of Petrolagar to maintain a regular bowel movement. Petrolagar softens hard stools and assists the bowel to function normally. Its pleasant flavor, devoid of the oily taste associated with plain mineral oil, makes Petrolagar very easy to take. Prescribe Petrolagar for bowel management, it's "Council Accepted." Petrolagar Laboratories, Inc. • Chicago, Ill.

Petrolagar . . . Liquid petrolatum 65 cc. emulsified with 0.4 Gm. agar in a menstruum to make 100 cc.

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- Thirteen years' acceptance by the Council of Pharmacy and Chemistry of the American Medical Association

A booklet summarizing the important reports on Mercurochrome and describing its various uses will be sent to physicians on request.

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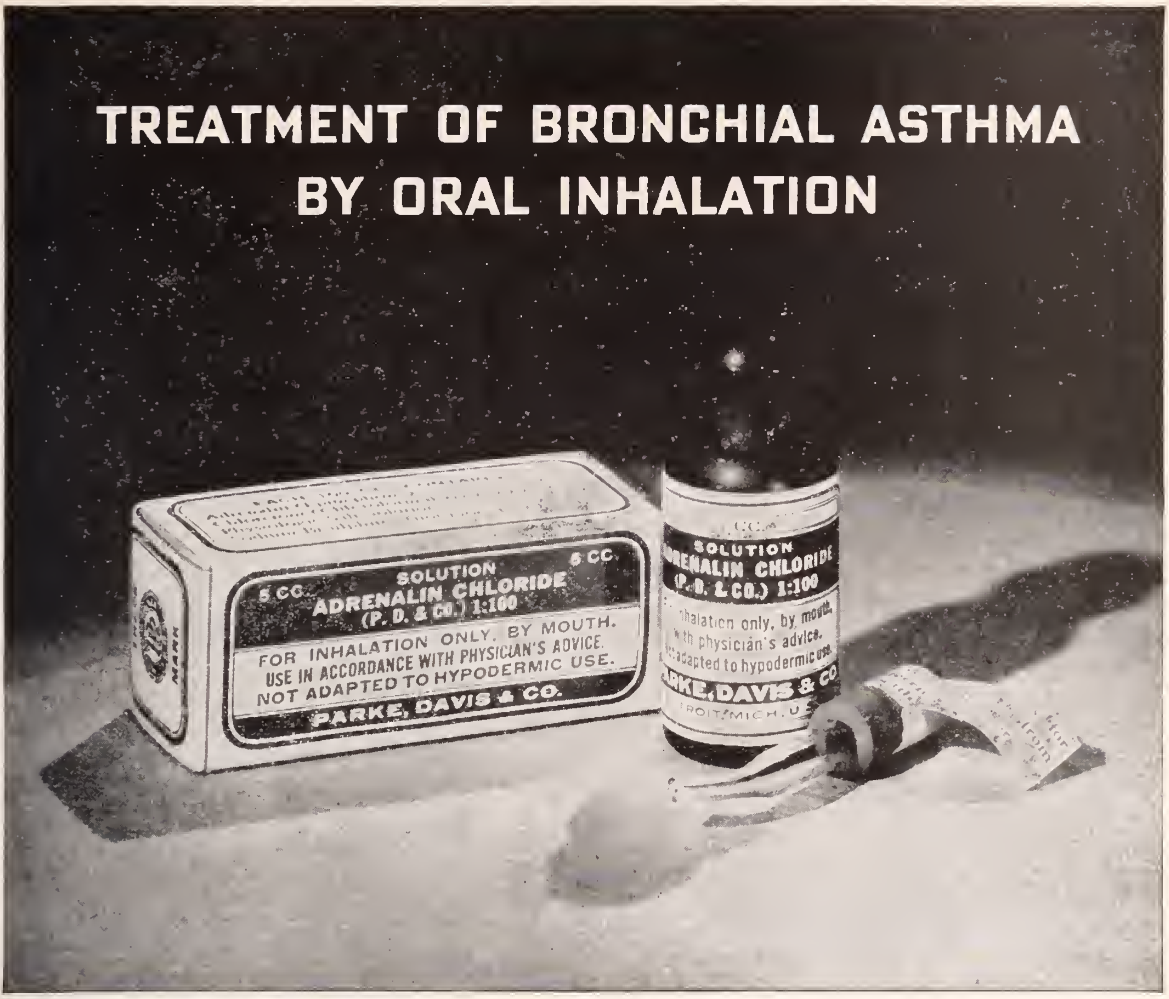

ADRENALIN CHLORIDE SOLUTION 1:100

THE oral inhalation of Adrenalin Chloride Solution 1:100 is promptly effective in relieving symptoms of bronchial asthma—in most cases results have been quite as satisfactory as those following hypodermic injection of the familiar 1:1000 solution. Nervousness and tachycardia, as well as other reactions which often accompany parenteral administration, are much less frequent following inhalation therapy. Discomfort and inconvenience of hypodermic injection are obviated by this new treatment.

Adrenalin is the Parke-Davis brand of Epinephrine U.S.P. Adrenalin Chloride Solution 1:100 is accepted by the Council on Pharmacy and Chemistry of the American Medical Association; it is supplied in 5-cc. vials, together with dropper for transferring the solution to a suitable atomizer, vaporizer, or nebulizer. The apparatus used must deliver a fine spray entirely free from drops.

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BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

IV. SEALING THE TIN CONTAINER

BRIEFLY, the method of food preservation commonly known as "canning" involves subjecting food in a permanently sealed container to a heat process. The heat process destroys spoilage organisms present on the raw food material; the seal on the container prevents reinfection of the food by such organisms. It is, therefore, obvious that the sealing operation—"closing" or "double-seaming" as it is known in the industry—is one of the most important in the canning procedure.

The manufacture of tinplate and "sanitary" cans is described elsewhere (1).

The open cans are received at the cannery in paper cartons or in washed paper-lined box cars, together with the covers which are contained in fiber shipping tubes. Figure 1 shows a can and end ready for use.

In modern canning practice, the cans are first conveyed by automatic runways to can washers, and thence to the filling tables or fillers where the correct amount of properly prepared raw food is put into the cans. The covers or "ends" are placed in the automatic sealing or "closing" machine to which the open can containing the food is mechanically conveyed. In this machine the ends are "double-seamed" onto the can. This operation is portrayed by the accompanying cross-sectional pictures.

In Figure 2 is shown the relation of can to cover before the sealing operation is started; note the relative position of the "curl" on the cover and the "flange" on the can. In this curl, the can manufacturer has placed a gasket or "compound," usually containing rubber. Figure 3 is a series of photographs illustrating the sealing operation in which the curl and flange are first rolled into position and then the layers of metal flattened together to form the final "double-seam" in Figure 4. The rubber compound originally present on the cover supplies the binding material between the layers of metal necessary to insure a permanent or hermetic seal on the container. Figure 5 illustrates in cross-section a closed sanitary can as it comes to the consumer.

In the past twenty-five years great progress has been made in the development of tinplate, compounds and automatic sealing machines. Collectively, these developments enable present-day canners to impose a permanent seal on the cans containing their products more easily and rapidly than ever before in the history of canning.

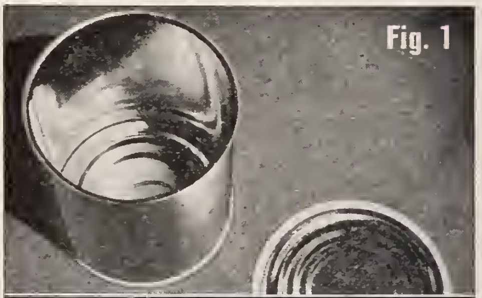
Fig. 1

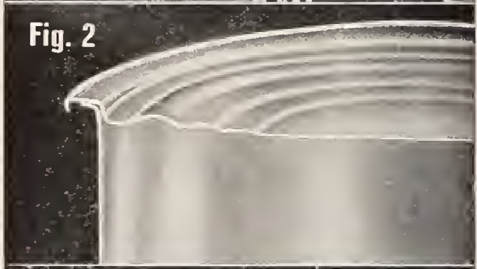
Fig. 2

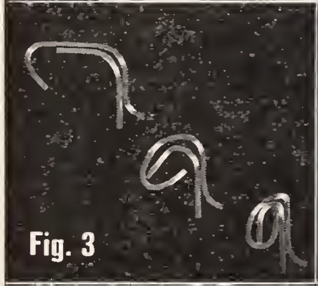
Fig. 3

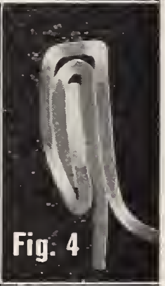
Fig. 4

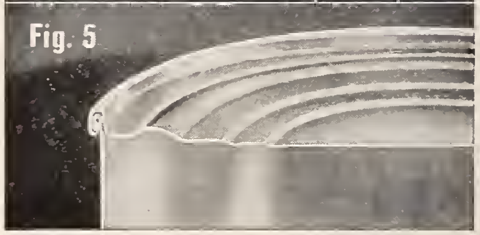
Fig. 5

AMERICAN CAN COMPANY

230 Park Avenue, N. Y.

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(1) The Story of the Tin Can, American Can Company, New York, 1935

This is the thirty-seventh in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

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WITH the many and varied claims made for cigarettes, *you* can be of assistance to your patients. With your scientific knowledge, you can discriminate between mere claims and basic facts.

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Ephedrine is one of the most acceptable vasoconstricting drugs for use in the nose. As the season for "summer colds" progresses, it is helpful to remember that Ephedrine Inhalants, Lilly, have established value in relieving the discomfort of this type of nasal congestion.

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Maine Medical Journal

The Official Organ of

The State and County Medical Societies

Vol. XXIX *Portland, Maine, June, 1938* *No. 6*

*Surgical Risks from a Medical Standpoint**

By John F. Kenney, M. D., F. A. C. P., *Chief of the Medical Service,*
The Memorial Hospital, Pawtucket, R. I.

In my opinion, although this may not agree with the average surgeon, the medical service in the average hospital gives a better work-up than the surgical service. The average surgical interne will not look at a case from the standpoint of the medical man and is very apt to concentrate with particular reference to the organ or part of the body to be operated upon.

The most important part in any risk is the history, perhaps even more important than any physical examination that you might carry out and especially with any reference to disease of the heart. In the classification as to the cause of heart disease, we have rheumatic, hypertensive, arteriosclerotic, syphilitic and long-drawn-out infections (streptococcus), so that you can see the importance of going back into the history.

A complete blood count is extremely important. The average surgeon will ask for a white count and a differential, whereas your patient may be definitely anemic and as you know the anoxemia resulting from anemia may bring on certain anginal attacks as it is not uncommon even for pernicious anemia cases to have the attacks of angina. An ischemia may also bring on anginal attacks at the least effort, therefore the arteriosclerotic history is important. These facts were brought out in a recent book by Samuel Levine on heart disease.

To show you how we work up our gall bladder cases and this is only an example that can be carried out for any type of cases. All gall bladder cases are admitted medically and a definite routine is carried out. I have already mentioned a careful history and a physical examination which is done before any of the various tests are done, and I might mention here that too much emphasis is placed in medical school upon laboratory procedures that are better carried out by well-trained technicians in the laboratory—this same amount of time had better be given over to good clinical and bedside instruction, although these same students should know how to do these tests and how to interpret the results, and to be taught to correlate the bedside and clinical findings with the laboratory reports and not, as is often done, correlate the laboratory reports with the physical examination. Complete blood and urine examinations; an icterus index; galactose test; a

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* Presented to the New England Surgical Association Meeting at the Memorial Hospital.

Takata Ara test; a Wasserman test; a Bromosulphethalein test; a blood cholesterol; hippuric acid test; a bleeding time and clotting time; and a blood typing are also done. A gastrointestinal series is frequently carried out in addition to other tests and depending upon what other physical findings are found, other tests are done which I have prepared for you in a mimeographed sheet. Naturally these are dependent, not done on all cases, but they are done when indicated.

All gall bladder cases except emergencies are admitted medically and when they are classified as to risk and before turning them over to the surgical service are checked by the anesthetist who decides on what type of anesthesia is best fitted for this risk. Most anesthetists use the classification of the American Heart Association which I will give at the end of this paper. In the bedridden patient the classification is based on history alone and in addition we have been carrying out two tests that have proven of value which I will describe in detail, that is, circulation time and venous pressure. These tests may be carried out by the interne.

CIRCULATION TIME DETERMINED BY THE USE OF SODIUM DEHYDROCHOLATE

(Decholin Sodium Bile Salt)

1. Use 3-5 c.c. of 20% sodium dehydrocholate (they used 3 c.c. at Mt. Sinai Hospital).
2. The faster the circulation the less substance needed.
3. 5 c.c. used in cardiac conditions.
4. Test performed in A. M. without breakfast.
    - a. *Patient* flat in bed.
    - b. *Arm* held at level of auricles.
    - c. *Apply* tourniquet just before injection.
    - d. *Tell* patient he will sense a bitter taste and respond the second he senses it.
    - e. Injection made rapidly with an 18-gauge needle and a 5-10 c.c. syringe.
    - f. Stop watch records time from the moment of injection to arrival of bitter taste.
    - g. 1-2 seconds required for injection.
    - h. Record time of start of injection rather than conclusion.
    - i. Taste reaction persists for 10-20 seconds.
    - j. Patient's attention can be distracted from any unpleasant condition by having him breathe deeply for 30 seconds.
    - k. May get nausea—rarely vomiting.
    - l. Test may be repeated as soon as desired. Usually do two tests to check.
    - m. Tongue taste must be intact.
    - n. Ca. Gluconate can be used—produces a feeling of heat in mouth and over body.

Thirty normal men and women tested (ages from 19 to 58 years). The average circulation time was 13 seconds.

Grave's disease are 9 seconds.
Heart failure are 30 seconds.
Emphysema—from 12 to 20 seconds.

Patient with heart disease and hypertension and no failure—10-19 seconds (average).

B-D DIRECT VENOUS PRESSURE APPARATUS

Venous pressure determinations are extremely valuable in cardio-vascular disease; an increase in venous pressure is one of the first signs of congestive heart failure.

As a diagnostic and prognostic aid, the knowledge of the upward or downward trend of venous pressure is of the utmost importance. It is valuable also in controlling medication and treatment.

Routine venous pressure determinations are recommended not only as a guide to venisection but also as a measure of its efficacy.

TECHNIQUE

Suggested by Lester Cohen, B. S., M. D.

"The instrument consists of an 18- or a 21-gauge short-bevel needle to which is attached the adaptor. This adaptor is fitted with a three-way valve system, and a Luer-Lok connection for a glass manometer tube. The glass manometer tube is calibrated to a total of 32 cm. (with an extension to a total of 48 cm.) and is attached to the adaptor in the upright position by means of a Luer-Lok connection. A 10 c.c. syringe completes the equipment. When the manometer tube is affixed to the adaptor, by means of the three-way fitting of the valve, blood can be withdrawn from the vein into the syringe containing either sterile saline or citrate solution, then the manometer tube is filled with this mixture, and by the third adjustment of the valve the direction of the flow is changed from the manometer tube to the vein.

The procedure adopted is as follows: The patient is kept at rest for a period of 15 minutes before the test. The right forearm is supported at the level of the right auricle and the antecubital fossa is prepared in the usual manner. A sterile 10 c.c. syringe containing 5 c.c. of sterile 3% sodium citrate solution is attached to the needle which is introduced into any suitable vein in the area, and a few c.c. of blood are drawn into the syringe. For this stage the valve must be kept in position No. 1.

The manometer tube is then affixed to its Luer-Lok connection, the valve is put in position No. 2 and is filled by injecting the contents of blood and citrate already present in the syringe. The valve is then set in position No. 3 and the aforementioned mixture is allowed to run into the vein. The level at which the fluid rests is read directly on the manometer tube as the venous pressure. The Valsalva phenomenon — expiratory effort with the chest held rigid in inspiration—is now applied to determine the continuity of the manometer tube with the venous stream. This will cause the venous pressure to rise markedly.

The entire procedure can be performed in five minutes, and requires no assistance. The advantages are the ease with which the readings can be determined, the firm attachment of manometer to adaptor without danger of breakage as when glass is directly fitted to metal, and finally, the ease with which this instrument can be cleaned.

Results obtained with the use of this instrument readily agree with the figures quoted by other workers. Normal variations of venous pressure have fallen in the range between 60-120 mm. In cases of heart failure, the figures have ranged as high as 400 mm. in the writer's experience. Repeated determinations have been done at short intervals without any ill effects."

Carrying out the routine that I have just outlined to you in our gall bladder cases alone, we have lowered our mortality in this hospital 9.2%, covering a two-year period as compared with a two-year period previous.

Facilities for the proper evaluation of a patient should be made available and access easily obtained by the well-qualified surgeons and at an expense that should not be a burden to his patient and leaving no financial return for the surgeon.

In other operative conditions the so-called bad risks must be taken into consideration when reports on the various tests are:

Basal metabolism above 50 (normal is from minus 15 to plus 15).

Blood pressure index below 25 or above 75 (80 to 140 is a normal pressure).

Breath-holding time is less than 25 seconds (normal is 25 seconds).

Sedimentation time under 1 hour (normal about 2 hours).

Non-Protein Nitrogen above 30 (normal 25 to 30).

Urea Nitrogen above 15 (normal 12 to 15).

Creatinine above 3 (normal 1 to 2).

Blood sugar above 200 (normal 80 to 120).

Alkali reserve above 75 (normal 50 to 75).

Blood calcium above 10 (normal 9-11 mg).

Chlorides below 300 (normal 400 to 600).

Phenosulphothalein excretion below 40% (2 hours); (normal is 40 to 50%—1 hour) (normal is 60 to 75%—2 hours).

Icterus Index above 20 (normal 8 to 16).

Quantitative Vandenbergh above 1 (normal .1 below).

Hippuric acid excretion less than 3 grams (normal 3 grams).

Galactose Tolerance Test above 5 (normal 3).

Bromosulphethalein Dye excretion of not more than 5% one-half hour after injection (zero after that).

Blood Cholesterol below 100 to above 200 (normal 140 to 180).

Normal circulation time, Grave's disease, 9 seconds; patients with heart disease or hypertension and no failure, average 10 to 15 seconds. Heart failure 30 seconds.

Venous pressure normal 60 to 120 mm.

E. K. G. is of value with particular reference in previous coronary disease.

The following is a classification outlined by the American Heart Association which may also be used to establish operative risks:

Class No. 1: Patients with organic heart disease able to carry on ordinary physical activity without discomfort. Ordinarily physical activity does not cause undue fatigue, palpitation, dyspnea or chest pain. Patients in this class do not show any physical signs of cardiac insufficiency and rarely signs of active infection.

Class No. 2: Patient with organic heart disease unable to carry on physical activities without discomfort.

A. Activity slightly limited. Ordinary physical activity causes undue fatigue, palpitation, dyspnea or chest pain. Patients in this class rarely show signs physically of cardiac insufficiency or of active heart infection.

B. Activity greatly limited. Less than ordinary physical activity causes fatigue, palpitation, dyspnea or chest pain. Patients in this class usually show one or more physical signs of cardiac insufficiency, the anginal syndrome or signs of active heart infection.

Class No. 3: Patients with organic heart disease and with symptoms or signs of cardiac insufficiency at rest, unable to carry on any physical activity without discomfort. There is fatigue, palpitation, dyspnea and chest pain at rest. Patients in this class show marked signs of cardiac insufficiency, anginal syndrome, or signs of active heart infection.

Further classification is important as:

No. 1. Possible Heart Disease. Patients who show abnormal signs or symptoms referable to heart but in whom diagnosis of heart disease is uncertain should be diagnosed as "Possible Heart Disease."

No. 2. Potential Heart Disease. Patients without heart disease, whom it is advisable to follow because of the previous history of an etiological factor which might cause heart disease, should be diagnosed as "Potential Heart Disease" and where possible the suspected etiological factor should be stated.

* * *

Pernicious Anemia with Subacute Combined Lateral Sclerosis

By E. H. Drake, M. D., Portland, Maine

The advent of liver therapy for pernicious anemia, dating from the year 1926, has increased the interest of the medical profession and the laity in this disease to the extent that cases less commonly go unnoticed. There do remain instances in which the diagnosis is puzzling. Patients of this sort usually fall into one of two groups: first, those in whom a number of remedies have been used in treating the anemia and after a favorable blood examination the exact etiology remains in doubt; second, cases in which the spinal cord changes have preceded the onset of the anemia. In twenty years various criteria for the diagnosis of angina pectoris have been in vogue. Finally the response of young erythrocytes in the circulating blood following liver therapy has come to be considered the most reliable means of diagnosis. The reticulocyte response begins within five days following the injection of liver extract, reaches its peak within another week, and thereafter the percentage of young red blood cells diminishes. There is, therefore, a time to search for the expected response early in treatment and a prospect that if the search is not made at that time the typical response will be missed and with it the chance for a correct diagnosis. The benefits of liver therapy in patients with Addisonian anemia have been so remarkable that liver extract has been frequently prescribed in other forms of anemia and often, as the many proprietory anti-anemic preparations bear witness, in combination with other drugs which of themselves aid recovery from anemia and may bring about some degree of reticulocyte increase. If the diagnosis is in doubt we should not fail to look at the proper time for the reticulocyte response to liver treatment but we must also guard against the simultaneous use, early in treatment, of other anti-anemic drugs which tend to confuse the therapeutic test.

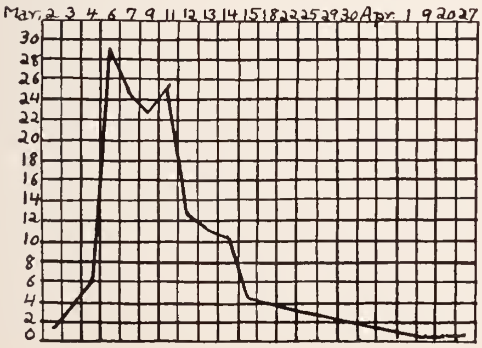
Before the advent of liver therapy, pernicious anemia patients, even in remission, failed to show an entirely normal blood. Some degree of anemia persisted and the abnormal morphology of the blood could still be recognized by study of the stained smears. Now the blood of pernicious anemia patients may become entirely normal; nevertheless, we know that the inherent lack of the intrinsic factor in the gastric secretion has not been overcome by a course of treatment and that this factor must be continually supplied in the form of tissue extract to prevent a recurrence of anemia, and, of even greater importance, the possible onset of irreparable central nervous system lesions. If we are to depend upon reticulocyte response and if the test has not been properly performed, we shall be uncertain regarding the necessity for the life-long administration of the anti-anemic factor.

Patients who develop the spinal cord lesion in advance of anemia will continue to present difficult problems in diagnosis. If the blood is normal there will be no reticulocyte response. It may be possible that certain of these individuals have suffered from previous anemia and this fact may be elicited by careful history taking. The association of glossitis with a spinal cord lesion must arouse the suspicion of absence of the anti-anemic factor even in this day when attention is particularly focused upon vitamin deficiency states.

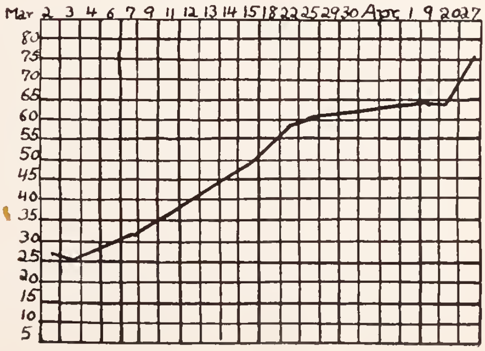
The patient to be presented is in the hospital for the second time. The first admission began July 10, 1936. He was a lumberman and stated his age as 65 years. He had been sent to the hospital because of unsteadiness of his gait, which had been noted for six months. This he felt was due to numbness of his feet and inability to tell their position while he was walking. He was obliged to look at the ground during locomotion in order to maintain his balance and he could not walk well at night. While the unsteadiness of gait had been present for only six months, he recollected numbness of both the feet and hands for as far back as two years. He had also been mildly short of breath on exercise. There had been a weight loss of ten pounds during the preceding six months. His dietary habits were not unusual except that he had been accustomed to eat meat only once or twice a week.

Physical examination showed a blood pressure of 174 mm. systolic; 100 mm. diastolic. A loud, rough, systolic murmur was to be heard over the entire precordium, but no cardiac enlargement was found. The peripheral arteries showed well-marked arteriosclerosis. The tongue was red and beefy, although the papillæ were not lost. There were Heberden's nodes on the fingers and it was observed that interosseous muscular atrophy was present in the hands. The face was expressionless. There was spasticity of the arms and legs and the gait was spastic, the hands being held rigidly with the thumbs tucked in. Rigidity of the upper extremities seemed to relax when he was in bed. The tendon re-

RETICULOCYTE IN %



HEMOGLOBIN IN %



flexes were hyperactive but equal. The Romberg sign was markedly positive. No Babinski or clonus was found. Position sense was poor, there was no change in tactile sensation except that vibratory sense was impaired over the mesial portion of the left foot and ankle. There were no evidences of congestive heart failure.

The hemoglobin was 76%, the red blood count 4,510,000 and the leukocyte count 8,100. The reticulocyte count was less than 1%. Kahn and Hinton tests were negative. Several urinalyses were negative. No free hydrochloric acid was found in the gastric contents on two examinations.

Intramuscular liver extract injections were given and daily reticulocyte counts made; the highest reticulocyte count obtained was 2%. There was local pain and tenderness after one of the intramuscular injections of liver and this was followed by pain in the right side of the chest, slight elevation of temperature and X-ray evidence of a small pulmonary infarction.

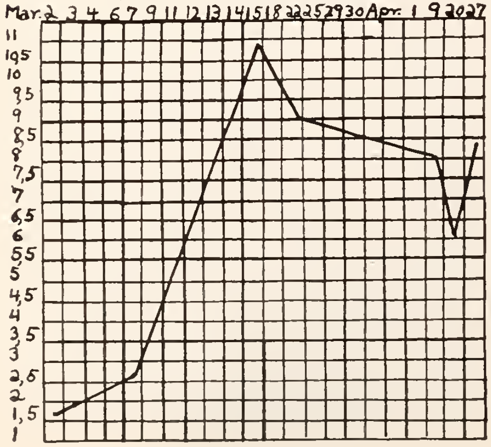
The gait improved with occupational therapy and re-education of the muscles and the patient was discharged August 6, without a unanimous decision as to diagnosis by the physicians who had seen him. The neurologist consultant favored the diagnosis of combined system disease.

The present hospital admission began February 1, 1938. The patient had returned with the same set of symptoms. He had improved for a time after his previous hospital admission, but the symptoms had become markedly worse in the preceding three months. He now noted difficulty in walking and in using his hands. He was unable to grasp small objects with certainty and felt as if he were walking on cotton. For six weeks there had been dyspnea on exertion, palpitation, cough and edema of the ankles.

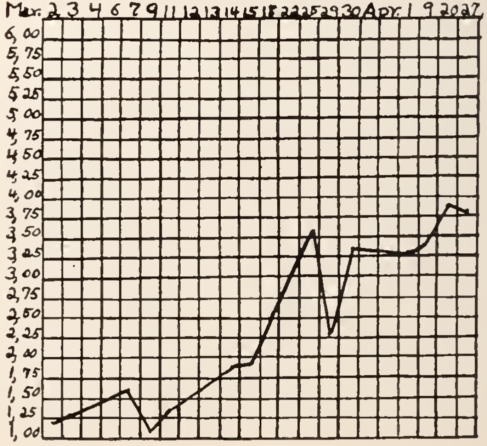
His blood pressure reading at admission was 134 mm. systolic; 76 mm. diastolic. Left-sided cardiac enlargement was found and the same systolic murmur noted at the time of previous admission. The liver edge was felt two inches below the right costal margin. Pallor of the skin and mucous membranes was evident. The Romberg was markedly positive and vibratory sense was entirely absent over both the lower extremities. Tactile sense was still preserved.

The initial hemoglobin estimation was 26%, the red blood count 1,210,000 and the leukocyte count 1,700 with 1% reticulocytes. Intra-muscular injections of liver extract and vitamin B were begun. In four days the reticulocyte count had reached 29%. During the period of two months and three weeks since admission 100 ampoules of liver extract have been administered;—this represents the extract from 650 to 1000 pounds of liver. The blood has gradually improved and there has been a nearly equal gain in symptoms from the spinal cord lesion. Walking is now accomplished without difficulty and the main remaining complaint is inability to distinguish the form of small objects held in the hands. Some numbness still persists in both the hands and feet.

LEUKOCYTE COUNT
IN THOUSANDS



RED BLOOD COUNT
IN MILLIONS



The presence of anemia at the last admission and a typical reticulocyte response followed by improvement in the blood allows us to conclude with certainty that the spinal cord lesion is subacute combined lateral sclerosis, depending upon primary anemia. It is of interest that the patient showed a remission from the spinal cord lesion after the first admission, even though anti-anemic therapy was not continued after discharge from the hospital. The return of cord symptoms was coincident with the drop in blood, as commonly occurs. It is a matter of good fortune that the patient returned to the hospital before becoming entirely unable to walk and that so much improvement in the cord lesion has resulted, during the second admission, from intensive intramuscular liver and vitamin B therapy. There is no doubt that treatment of this sort should be continuously administered during the remainder of the patient's life, even though the blood has returned to normal and improvement in the symptoms from the spinal cord lesion has ceased.

◆

Graduate Medical Education Opportunities in Maine

The Medical profession in Maine is singularly fortunate in opportunities for graduate study. The lack of a medical school in the State may contribute to one's feeling of a serious deficiency in study opportunities. On reflection, however, it becomes obvious that undergraduate schools of medicine are not designed for graduate study and that whatever formal or informal graduate instruction exists is generally dissociated from undergraduate courses. Hence this lack is not in any real sense a deterrent to the acquisition of graduate instruction. Graduate study in medicine takes on varieagated forms and the physician is at all times engaged in some aspects of it such as in the scientific conferences conducted by the State and County Medical Societies, the staffs of the various hospitals, and independent medical organizations. In fact all case studies, and particularly those in which consultations are employed, may well be included under the category of graduate instruction in a broad sense.

In hospitals with a formal plan for local graduate instruction a guest physician or surgeon of eminence is periodically invited to conduct teaching clinics. Cases which have been thoroughly studied are presented at these clinics; the visiting physician reviews the case and a general discussion follows. In addition to case presentations and round table discussions, a formal paper is presented in the evening, bringing to the attention of the group the more recent advances in that field in which the guest physician is particularly interested.

The unique position and advantages for advancement of medicine in Maine is based upon the singular opportunities for graduate studies made possible through the Fellowships offered by the Commonwealth Foundation and the Bingham Associates. The Commonwealth Foundation Fellowships are available to physicians in the smaller communities who wish to pursue graduate work. A full description of their aims and accomplishments was recorded in the editorial columns of the *American Medical Association Journal*, January 15, 1938, issue and more recently outlined in the MAINE MEDICAL JOURNAL (January, 1938).

The Bingham Associates has as its primary interest the advancement of rural medicine in Maine. For the last few years it has been developing a plan having as its objective the making available to those ill in the smaller communities, the same type of medical attention provided in metropolitan centers. This program is to be accomplished through three interlocking plans. The first of the steps is post-graduate instruction for practicing physicians through Fellowship grants.

The next step is the development of diagnostic facilities. The Joseph H. Pratt Diagnostic Hospital in Boston coöperating with Tufts Medical School is the center for this development. Doctors may refer to this hospital patients presenting problems requiring group specialized advice. Reports and opinions are given only to the referring physicians, who in turn advises his patient. The doctor is at all times privileged to visit the diagnostic institution, to contribute his opinions and to confer and study the case with his associates at the Diagnostic Hospital. This offers an effective plan of graduate study inasmuch as it makes available the special facilities of the Diagnostic Center and at the same time retains intimacy of contact between the physician and the patient, whom he will continue to care for after the more elaborate and technical studies are completed.

The third step arranges for an interchange of facilities. Technicians with a knowledge of latest advances of laboratory procedures are attached to rural hospitals, returning periodically to the Medical Center to keep abreast of technical advancements. The development of this phase will obviate the necessity, in many instances, of referring patients for diagnoses to out-of-state hospitals, inasmuch as it will provide diagnostic facilities not now available in several sections of the State.

It is recognized that more intensive and comprehensive studies on a patient are desirable adjuncts to graduate study and that the removal of a medical problem is not conducive to the medical advancement of any community. In principle, therefore, only such patients as present unusually obscure problems and have exhausted the diagnostic facilities in Maine are to be accepted by the Diagnostic Hospital. The objective of the plan is not to simplify medical practice in Maine but to intensify and amplify it and to give to patients in the more rural districts medical facilities at present not available.

Medical progress in this Country has experienced a phenomenally rapid vertical ascendency in the sense that highly specialized and research institutions have contributed a mass of medical knowledge. This may be termed the productive stage of medical knowledge so laboriously and skillfully accumulated. The three-point program as outlined above may be contrastingly described as the horizontal phase—or phase of better distribution. The numerous contributions and attainments are obviously of little value unless applied to the sick. Illness met in the most isolated rural districts may be as complex and diversified as illness in the largest metropolitan districts requiring equal skill and knowledge. This objective may be impossible of complete realization. The ideal to be striven for is, however, worthy of effort even if only partially attained.

J. Gottlieb, M. D.,
Member of the State Committee on Graduate Education.

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Editorial

The Committee on Supply of Medical Service

One of the most important services to be undertaken by organized medicine is the proposed nation-wide study of medical and health needs. Emphasis is laid on the importance of this effort being conducted by the various state medical societies, for through the units of the county societies it will be possible to obtain and analyze *local* medical and healths needs and conditions. The committee appointed by the American Medical Association warrants our confidence and earnest support. It must be recognized, given a problem as to the supply and type of medical service in any locality, experienced medical analysis must offer the best solution. Individual physicians constitute the ultimate factor in providing such services; hence this study will ask that all members of county societies assist in procuring the required information and it will also include any organizations or individuals which may offer any information or assistance. If needs exist, and who is better able to determine the fact than the general practitioner in that locality, from him the committee wants his best advice in determining the means how a better and wider distribution of medical service may be had by all who seek it under obtaining conditions.

What the central and state committees require, and must have to give of their best advice, is a complete picture of the situation in a given locality from various points of view. Advice or suggestions will come from the central committee to the various state medical societies and through them to the county societies in developing suitable *local* plans for meeting such needs as may exist, with the facilities available, and if such facilities are not sufficient to suggest means to better them. This is an effort organized medicine cannot afford to muff and plenty of assurances are forthcoming that it will not. The study goes back to the grass roots, the county societies; it is to be made under the auspices of organized medicine and all others whose interest and experience will be helpful and in this way, and no other, can a correct estimation be made and the proper services obtained.

There are many reasons, entirely divorced from sentiment, why any community can ill afford to allow the medically indigent to go without adequate medical care. Such persons are certain to incubate and spread diseases which will result in a far heavier tax on the public purse than that imposed by furnishing help at the proper time and by the proper persons. Neglected illness or injury, especially in the bread winner of a family, can easily result in placing that entire family on public charity. In a straight-from-the-shoulder talk given at the dedication of the new wing of the State Tuberculosis Sanitarium at Hazlewood, Kentucky, on March 28, Governor A. B. Chandler said in part as follows: "Opportunists talk very glibly about health insurance, the socialization of medicine and the regimentation of physicians as the remedy for this situation. Such suggestions will receive no support from the people of Kentucky. *We will continue to be guided in regard to public health and medical service by our doctors.* Realizing that the profession has been very busy in reducing the death rate from acute and infectious diseases, we will patiently await their *examination and diagnosis* in regard to the medical conditions that confront us, and we will be *guided* by them with perfect confidence that they will continue to give our people all that modern science can give toward making Kentucky the healthiest, the happiest and most effective people in these United States. The complete coöperation of every physician in this worthwhile study and effort means much in end results. Remember: surveys and suggestions have come in abundance from foundations, committees of various kinds and individuals the past few years. Whether such reports constituted a picture of exact conditions can be left to the conclusions of the reader, after thinking over the motives of the makers. Organized medicine, when this study is completed and analyzed, will have a true picture of conditions as they exist nation-wide.

RALPH W. WAKEFIELD, M. D., F. A. C. S.

President Maine Medical Association

The President's Page

To the Members of the Maine Medical Association:

Since this is the last time I will have the pleasure of addressing you through this page, I take the opportunity to thank the officers and members of the various County Medical Societies for the uniform courtesy and kindness they have extended to me during my official visits.

Of the manifold duties of your President, the most pleasing to me has been these visits to the County Medical Societies, renewing old acquaintances and making new ones.

It has also been a real pleasure to work with our new Secretary-Treasurer, Dr. Frederick R. Carter of Augusta and his able assistant, Mrs. Esther Kennard of the Portland office.

Dr. Carter's long experience as Secretary of the Kennebec County Medical Society made him unusually competent for the larger work of Secretary-Treasurer of the Maine Medical Association and only enlarged his field of activity.

His kindly patience and unfailing courtesy wins the friendship of all of those with whom he comes in contact. We are, indeed, fortunate in having Dr. Carter in this responsible position.

I again call your attention to the programme, given in detail in this number of the JOURNAL, to be presented at Bar Harbor on June 26th, 27th and 28th. With good roads leading to Mt. Desert Island and unsurpassed scenery after you arrive, with fine hotel accommodations and an excellent programme for the convention, this should be one of our largest and most successful meetings.

Thanks to the editors of the JOURNAL, this publication is constantly improving and although there is still much to be desired, I believe the improvement will be constant and progressive under the present management.

Lastly, I urge you to visit the commercial exhibits during the convention. These commercial houses pay us well for the privilege of exhibiting their wares and it is only fair and decent that we give them a cordial greeting and see what they have to offer.

RALPH W. WAKEFIELD, M. D.

Report of the Secretary-Treasurer

As secretary I am pleased to submit the following annual report:

There are 672 active members in good standing in the Association, two paying direct and 25 honorary. We have added to our roster 32 new members since June, 1937, and have lost 19 through death.

In accordance with our By Laws, Chapter VIII, Section 1, we dropped 19 members for non-payment of dues in April. Ten have been reinstated.

At the June meeting, the Association will have the privilege of presenting Fifty-Year Service Medals to Drs. Bertrand F. Marshall, Westbrook, Jesse A. Randall, Old Orchard, and George W. Weeks, Cornish, in recognition of the service which they have rendered during fifty years in the practice of medicine.

The report of the Council for the year will be given by the chairman, Dr. Thomas A. Foster, at the first meeting of the House of Delegates to be held Sunday, June 26th at 4.30 P. M., at Bar Harbor.

The 1937 fall clinical session was held in Portland, October 21st and 22nd. The program was very interesting and instructive, and was well attended. There were 212 members present.

Commercial Exhibits: We have reserved space for 22 reliable firms to display their commercial products at the Bar Harbor meeting, for which they will pay the Association $598.00. I hope the members will make an effort to visit the exhibits.

Your secretary wishes to express his appreciation for the generous and active cooperation of the various county secretaries, councillors and other officers of the Association in carrying on the work of the Association.

The books of the Association and JOURNAL were closed and audited May 31, 1938. The audit will be found in this issue.

Respectfully submitted,
FREDERICK R. CARTER, M. D.,
Secretary-Treasurer.

May 31, 1938.

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Delegates and Alternates to the 1938 Annual Session

Androscoggin:
W. L. Haskell, Lewiston.
A. W. Plummer, Lisbon Falls.
W. E. Webber, Lewiston.

Alternates:
Henry Sprince, Lewiston.
E. J. Marston, Auburn.
B. W. Russell, Lewiston.

Aroostook:
W. B. Gibson, Houlton.
H. C. Kimball, Fort Fairfield.

Cumberland:
E. R. Blaisdell, Portland.
Langdon T. Thaxter, Portland.
Ralph A. Getchell, Portland.
Luther G. Brown, Portland.
William D. Anderson, Portland.
T. M. Stevens, Portland.
H. W. Hanson, Jr., Cumberland Center.
J. C. Oram, South Portland.

Franklin:
A. E. Floyd, New Sharon.

Alternate:
M. R. Colley, Wilton.

Hancock:
George A. Neal, Southwest Harbor.

Alternate:
R. W. Clarke, Ellsworth.

Kennebec:
Howard F. Hill, Waterville.
Maurice A. Priest, Augusta.
C. G. Farrell, Gardiner.

Alternate:
Armand Guite, Waterville.

Knox:
C. H. Jameson, Rockland.
C. B. Popplestone, Rockland.

Alternates:
A. F. Fuller, Pemaquid.
William A. Ellingwood, Rockland.

Oxford:
R. R. Tibbetts, Bethel.

Alternate:
H. M. Howard, Rumford.

Penobscot:
F. B. Ames, Bangor.
H. C. Scribner, Bangor.
H. C. Knowlton, Bangor.
H. E. Thompson, Bangor.

Alternate:
L. H. Smith, Winterport.

Piscataquis:
F. J. Pritham, Greenville Junction.

Alternate:
W. B. S. Thomas, Dover-Foxcroft.

Sagadahoc:
A. F. Williams, Augusta.

Somerset:
E. D. Humphreys, Jackman.

Alternate:
George Young, Skowhegan.

Waldo:
Foster C. Small, Belfast.

Alternate:
E. L. Stevens, Belfast.

Washington:
D. F. Bennett, Lubec.

Alternate:
John Murphy, Eastport.

York:
E. C. Cook, York Village.

Alternates:
E. M. Cook, York Harbor.
C. W. Kinghorn, Kittery.

Official Delegates to the Maine Medical Association

Connecticut State Medical Society:
Alfred C. Henderson, Stamford.
Ralph A. McDonnell, New Haven.

The Massachusetts Medical Society:
Frank W. Snow, Newburyport.
Charles F. Warren, Amesbury.

The New Hampshire Medical Society:
Wendell P. Clare, Portsmouth.
Lawrence R. Hazzard, Portsmouth.

Rhode Island Medical Society:
G. G. Dupre, Woonsocket.
William Cutts, Providence.

Vermont State Medical Society:
C. G. Schurman, Newport.

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SCIENTIFIC COMMITTEE

In charge of program for the
Eighty-sixth Annual Session of the Maine Medical Association

JOHN O. PIPER, *Chairman*

STEPHEN A. COBB

M. S. F. GREENE

H. W. GOODWIN

FREDERICK R. CARTER

Maine Medical Association, Eighty-sixth Annual Session

Sunday, Monday and Tuesday — June 26th, 27th, 28th, 1938

(DAYLIGHT SAVING TIME)

Program in Brief

SUNDAY, JUNE 26TH

4.30 P. M. First Meeting of the House of Delegates
8.00 P. M. Entertainment for the doctors and their wives

MONDAY, JUNE 27TH

9.30 to 12.00 A. M. Conferences
12.30 P. M. Luncheon
Tables will be reserved for reunions of alumni of Boston University, Johns Hopkins, Bowdoin, McGill and Harvard University Medical Schools.
2.00 to 4.45 P. M. Scientific Session
5.00 P. M. Election of President-elect
5.30 P. M. Second Meeting of the House of Delegates
7.00 P. M. Dinner
8.00 P. M. Cancer Symposium

1. Frank E. Adair, M. D., Memorial Hospital, New York City, Chairman of the Committee of Malignancy, American College of Surgeons: — "Newer Additions to Diagnosis and Present Status of Therapy of Breast Tumors." 45 minutes
2. Dr. C. C. Little, Director, Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine:—"Outline of the Biological Approach to the Experimental Study of Breast Tumors." 10 minutes
3. Miss Elizabeth Fekete, Research Associate, Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine:—"Mammary Gland as a Site of Neoplastic Growths." 20 minutes
4. A. M. Cloudman, M. D., Research Associate, Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine: — "Histopathology of Breast Tumors in Mice in Relation to Genetics." 20 minutes
5. J. J. Bittner, M. D., Research Associate, Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine: — "Transmitted Influences affecting the Incidence of Breast Tumors in Mice." 20 minutes

TUESDAY, JUNE 28TH

9.30 to 12.00 A. M. Conferences
12.30 P. M. Past Presidents' and County Secretaries' Luncheons
2.00 to 5.00 P. M. Scientific Session

7.00 P. M. Banquet—(Dress Informal)
Introduction of Visiting Delegates by President Ralph W. Wakefield, M. D.
Presentation of Fifty-Year Service Medals by Governor Lewis O. Barrows
Speakers:
Governor Lewis O. Barrows
G. Allan Craig, M. D., Bangor (The Doctor, Family Friend or Public Servant)
Frank Lahey, M. D., Boston (The Medical and Surgical Management of Peptic Ulcer)

Conferences

MONDAY, JUNE 27TH, AT 9.30 A. M.

1. *Medical Examiners' Meeting and Conferences,* John G. Towne, M. D., Waterville, Presiding

2. *Obstetrical,* R. L. Reynolds, M. D., Waterville
Some unusual complications in early pregnancy. Importance of early observation in prenatal care.

3. *Medical,* Eugene H. Drake, M. D., Portland
Diseases of the thyroid. Classification of causes of thyroid enlargement. Interpretation of basal metabolic rate determinations. The iodine test. Cholesterol and calcium metabolism. Thyroid heart disease. Hypothrodism and myxedema.

4. *Surgical,* T. S. Moise, M. D., Bangor
Empyema.

5. *Tuberculosis with Special Reference Given to Skin Testing,* Allan Craig, M. D., Bangor; assisted by Albert Fellows, M. D., Bangor; and Walter R. Gumprecht, M. D., Bangor

6. *Blood Dyscrasias,*
Mortimer Warren, M. D., Portland; Herbert E. Thompson, M. D. Bangor

To be discussed as a dialogue:

1. Fundamental Conception
2. Blood Conditions Discussed with Variations
    (a.) Lymphocytes
    (b.) Monocytes
    (c.) Granulocytes
    (d.) Erythrocytes
3. What are Blood Diseases
4. Classification of Uremia
5. Classification of Lukemia
6. Classification of Hemorrhagic Conditions
7. Miscellaneous Conditions
8. Important Points in Diagnosis of Blood Dyscrasias
9. Résumé of Principles of Treatment

MONDAY, JUNE 27TH, AT 11.00 A. M.

1. *Medical Examiners' Conference* (Continued).

2. *Lateral Sinus Thrombosis,* Harry Butler, M. D., Bangor
Anatomy, Pathology, Pathways of Injection, Blood Picture, Temperature, Ayre-Tobey Test, Final Diagnosis, Schools of Treatment.

3. *Nervous and Mental Disorders*
   1. Points of Special Significance in Differential Diagnosis of Organic and Functional Psychosis, Forrest C. Tyson, M. D., Supt., Augusta State Hospital, Augusta
   2. Significance of Neurological Symptoms in Diagnosis of Organic Brain Diseases, Henry M. Swift, M. D., Portland
   3. Treatment and Prognosis in the More Common Forms of Brain and Nerve Injuries, H. Eugene Macdonald, M. D., Portland
   4. The Significance of Psychogenic Symptoms in the Treatment of the More Common Nervous Disorders, Owen B. Ames, M. D., Fairfield
   5. Psychiatric problems in Veterans' Bureau Cases, Sherwood Dix, M. D., Veterans' Facility, Togus
   6. Results of Insulin Treatment in Cases of Dementia Præcox, Max E. Witte, Jr., M. D., Bangor State Hospital, Bangor
   7. Mental Defect. Two brothers presenting the Laurence-Moon-Biedl Syndrome, N. S. Kupelian, M. D., Supt., Maine State School, Pownal
   8. Types of Cases Observed in a Children's Psychiatric Clinic, Vernon P. Williams, M. D., Boston, Mass., Children's Service Bureau Psychiatric Clinic, Portland

4. *Surgical,* Charles W. Bell, M. D., Farmington
Experiences during forty years of rural practice.

5. *The Newer Forms of Insulin,* Elton R. Blaisdell, M. D., Portland

6. *Blood Dyscrasias* (Continued), Mortimer Warren, M. D., Portland; Herbert E. Thompson, M. D., Bangor

TUESDAY, JUNE 28TH AT 9.30 A. M.

1. *Early Syphilis,* Benjamin B. Foster, M. D., Portland; A. H. Morrell, M. D., Augusta
Motion and still pictures of treatment technique. Indications for treatment as practised at the Portland clinics. Discussion of treatment of different stages of syphilis and choice of drugs. Discussion of fever therapy combined with drug therapy in the treatment of syphilis.

2. *Eye Conference,* Howard F. Hill, M. D., Waterville
Résumé of complications encountered. Treatment and suggestions as to avoiding them.

3. *Urinary Calculi,* Clinton Peters, M. D., Portland
Etiology, theories of stone formation, and general care in handling all of the cases, including their treatment, and possible prevention of formation.

4. *Geriatrics,* Lawrence M. Cutler, M. D., Bangor

5. *Management of More Common Complications of Acute Respiratory Infections,*
Henry P. Johnson, M. D., Portland
A discussion of the treatment of the acute sinusitis, peritonsillar abscess, cervical adenitis and infections of the middle ear and mastoid.

6. *X-ray,* Langdon Thaxter, M. D., Portland; Forrest B. Ames, M. D., Bangor, et al
Roentgen ray. Conference on unusual cases.
(Any man having X-ray films he would like to have discussed is welcome to bring them to this conference.)

TUESDAY, JUNE 28TH, AT 11.00 A. M.

1. *Surgical,* Alvin E. Ottum, M. D., Portland
Procedures in diagnosis and treatment of sterility.

2. *Pediatrics,* Thomas A. Foster, M. D., Portland; R. L. Huntress, M. D., Portland
Pyuria in infancy and childhood.

3. *Biochemical Aids in Clinical Diagnosis,*
Julius Gottlieb, M. D., Lewiston; Milan Chapin, PH.D.
Underlined chemical principles of clinical laboratory procedures. Presentation of normal values and a discussion of abnormal values in various clinical syndromes.

4. *Liver Function Tests in the Diagnosis of Jaundice,* Paul Chevalier, M. D., Lewiston

5. *Management of Common Obstetrical Problems,* L. C. Gross, M. D., Lewiston
    1. Diagnosis and Treatment of Pre-eclamptic Patients.
    2. Management of Pernicious Vomiting.
    3. Bleeding during the latter part of Pregnancy.

6. *X-ray* (Continued),
Langdon Thaxter, M. D., Portland; Forrest B. Ames, M. D., Bangor, et al

Scientific Session

MONDAY, JUNE 27TH, AT 2.00 P. M.

The President's Address, Ralph W. Wakefield, M. D., Bar Harbor

Symposium on Acute Respiratory Infections.

1. *Upper Respiratory Infections,* Frederick T. Hill, M. D., Waterville
Discussion opened by R. M. McQuoid, M. D., Bangor.

2. *Lower Respiratory Infections,*
Donald King, M. D., Massachusetts General Hospital, Boston
Discussion opened by Charles Steele, M. D., Lewiston.

3. *Pneumonias of Infancy and Childhood.* J. L. Wilson, M. D., Detroit, Mich.
Discussion opened by Merrill S. F. Greene, M. D., Lewiston.

4. *Surgical Treatment of the Complications of Pneumonia,*
Edward D. Churchill, M. D., Massachusetts General Hospital, Boston
Discussion opened by George E. Young, M. D., Skowhegan.

TUESDAY, JUNE 28TH, AT 2.00 P. M.

1. *The Low Transverse Cervical Cesarean Section,* Adam P. Leighton, M. D., Portland
Discussion opened by Roland B. Moore, M. D., Portland.
2. *Control and Management of Puerperal Infection,*
John R. Fraser, M. D., Montreal, Professor Gynecology and Obstetrics, McGill University
Discussion opened by Walter F. W. Hay, M. D., Portland.
3. *Endocrinology in Relation to Obstetrics and Gynecology,*
Fuller Albright, M. D., Massachusetts General Hospital, Boston
Discussion opened by Henry C. Knowlton, M. D., Bangor.
4. *Medical Publicity,* Frank H. Jackson, M. D., Houlton
Discussion opened by John O. Piper, M. D., Waterville.

Golf Tournament

There will be a golf tournament for all members of the Maine Medical Association and invited guests on June 27th and 28th at the Kebo Valley Country Club. All matches will be for 18 holes medal play, under U. S. G. A. tournament rules, and scores will be based on the State or home club handicap of each player. Matches may be played either Monday or Tuesday, all scores to be attested and passed to Shirley Liscomb, professional of the Kebo Club, at the end of play. All players desiring to play in the tournament must post his name before entering. Prizes will be for first, second and third gross and first, second and third net.

Advance entries, which will materially aid the committee, may be made to C. C. Morrison, Jr., M. D., Bar Harbor, or Forrest C. Tyson, M. D., of Augusta. Those, however, finding it impossible to make an advance entry will be taken care of the days of the tournament by either member of the committee or Mr. Liscomb.

A kickers' handicap match will also be played the same dates for which one prize will be offered. Playing privileges will be $2.00 daily.

For the Ladies

There will be bridge tournaments arranged for the ladies, both Monday and Tuesday, and ample means for tours to the interesting places in and about Bar Harbor, including Cadillac Mountain.

Our Exhibitors

The average physician has little time and opportunity to become acquainted with the rapid advances being made in pharmaceutical preparations, surgical instruments and scientific apparatus. No little of the success and value of our State and National meetings is due to the carefully prepared exhibits of new drugs, scientific instruments and appliances. The manufacturers purchase space for the exhibition of their products and they go to no little expense in providing and maintaining the personnel required for acquainting us with developments and advances of interest and importance. Physicians attending these meetings can well, and should, afford these commercial friends some of their time and attention. We cannot practice medicine successfully without their help; they cannot exist and advance without our patronage which they deserve for products of merit. It is well, also, to remember that without these exhibitors a heavy expense would entail upon our various treasuries. We must have proper and sufficient accommodations for our scientific meetings and business affairs. All this made possible and less burdensome by the support and coöperation of those who exhibit before us. Let us, then, show our appreciation by a good attendance and obtain at first-hand information of great value.

Treasurer's Report

JORDAN & JORDAN
Accountants and Auditors
Fidelity Building
Portland, Maine

May 31, 1938.

Maine Medical Association and Journal,
Portland, Maine.

Gentlemen:—We respectfully report that we have completed our audit of your accounting records from May 23, 1937, to May 31, 1938, inclusive, and have found the same complete and correct in all details of record. Statements annexed hereto are, in our opinion, properly drawn up to show the true financial position of the Association May 31, 1938, and income and expense for the period under review.

Respectfully submitted,

Jordan & Jordan,
Accountants and Auditors.

MAINE MEDICAL ASSOCIATION AND JOURNAL

Balance Sheet, May 31, 1938

ASSETS

Cash in Banks,	$15,523.97	
Accounts Receivable—Sundry,	227.00	
Dues Receivable—1938,	56.00	
Advertising Receivable—1938,	284.55	
Securities (Cost) (See Schedule Attached),	7,405.00	
Furnishings and Equipment,	674.43	
Impounded Cash,	1,990.63	
Total assets,		$26,161.58

TRUST FUND INVESTMENTS

Prince A. Morrow Fund:			
12 Shares American Agricultural Chemical Co., (Cost),	$ 348.00		
Savings Account No. 3905, Canal National Bank,	365.71		
Savings Account No. 54236, Fidelity Trust Co., Impounded,	84.96		
		$ 798.67	
Thayer Library Fund:			
Savings Account No. 3903, Canal National Bank,	$ 871.01		
Savings Account No. 54631, Fidelity Trust Co., Impounded,	471.84		
		1,342.85	
Total Investments,			2,141.52
Total Assets and Fund Investments,			$28,303.10

LIABILITIES AND CAPITAL

Deferred Income:			
Exhibit Space—1938 Exhibition,		$ 598.00	
Capital Account—May 31, 1938,		25,563.58	
Total Liabilities and Capital,			$26,161.58

TRUST FUNDS

Trust No. 1—Prince A. Morrow Fund,	$ 568.52		
Unexpended Income,	230.15		
		$ 798.67	
Trust No. 2—Thayer Library Fund,	$1,229.72		
Unexpended Income,	113.13		
		1,342.85	
Total Trust Funds,			2,141.52
Total Liabilities, Capital and Trust Funds,			$28,303.10

Capital Account, May 23, 1937, to May 31, 1938, Inclusive

Maine Medical Association:			
Balance—May 23, 1937,		$24,599.02	
Deduct:—1937 Expenses:—Medals,	$27.00		
Gift for Miss Gardner,	55.00		
Massachusetts Delegate,	12.20		
		94.20	
		$24,504.82	
Add:—Revenue in Excess of Expense,		602.99	
			$25,107.81
Maine Medical Journal:			
Balance—May 23, 1937,		$396.49	
Deduct:—1937 Expenses and Refunds:			
Dr. Jackson's Expenses,	$25.00		
Refund—Plates,	8.08		
		16.92	
		$379.57	
Add:—Revenue in Excess of Expense,		76.20	
			455.77
Balance—May 31, 1938,			$25,563.58

Statement of Revenue and Expense, May 23, 1937, to May 31, 1938, Inclusive

REVENUE

	Total	Association	Journal
Dues,	$5,340.00	$5,340.00	
Income from Securities,	309.50	309.50	
Interest Received,	225.54	225.54	
Exhibit Space, 1937 Convention,	505.50	505.50	
C. M. A. B. Advertising,	2,030.15		$2,030.15
Subscriptions and Sales of Journals,	15.06		15.06
Local Advertising,	1,113.62		1,113.62
Total Revenue,	$9,539.37	$6,380.54	$3,158.83

EXPENSE

Traveling Expenses:			
President's Traveling Expenses,	$ 150.00	$ 150.00	
Councilors' and Secretary's Expenses,	200.55	200.55	
Salary—Editor's—Dr. Jackson,	1,000.00	1,000.00	
Salaries—Augusta Office:			
Dr. Carter, Secretary,	923.04	923.04	
Miss Boston,	105.00	105.00	
Salaries—Portland Office:			
Miss Gardner, Secretary,	225.00	225.00	
Mrs. Kennard, Assistant Secretary,	1,290.00	1,290.00	
Miss Hider,	12.00	12.00	
Office Expenses:			
Supplies, Stationery, etc.,	315.90	269.03	$ 46.87
Postage and Mailing Expense,	184.50	68.00	116.50
Telephone,	87.81	87.81	
Auditing,	54.00	54.00	
Safe Deposit Box Rental,	5.50	5.50	
Plates,	112.89	112.89	
Miscellaneous,	80.58	43.38	37.20
Clinical Session,	71.50	71.50	
A. M. A. Meeting,	76.70	76.70	
Medical Advisory Committee,	500.00	500.00	
Annual Meeting,	583.15	583.15	
Printing,	2,882.06		2,882.06
Total Expense,	$8,860.18	$5,777.55	$3,082.63
Revenue in Excess of Expense, 12 Months, 9 Days,	$ 679.19	$ 602.99	$ 76.20

Statement of Cash Receipts and Disbursements, May 23, 1937, to May 31, 1938, Inclusive

	Total	Association	Journal
Cash on Hand, May 23, 1937,	$14,682.93	$13,991.47	$ 691.46
RECEIPTS			
Received from Dues—1938,	$ 5,376.00	$ 5,376.00	
Received from Dues—1937,	208.00	208.00	
Income from Securities,	309.50	309.50	
Interest Received,	225.54	225.54	
Exhibit Space—1938 Convention,	371.00	371.00	
Exhibit Space—1937 Convention,	140.00	140.00	
Advertising—Local,	1,134.79		$1,134.79
Advertising—C. M A. B.,	1,983.98		1,983.98
Subscriptions and Sale of JOURNAL,	15.06		15.06
Miscellaneous Refunds, etc.,	9.91	9.91	
Liquidating Dividends—Fidelity Trust Co.,	205.50	202.25	3.25
Total receipts,	$ 9,979.28	$ 6,842.20	$3,137.08
	$24,662.21	$20,833.67	$3,828.54
DISBURSEMENTS			
Traveling Expenses:			
President's Traveling Expenses,	$ 150.00	$ 150.00	
Councilors' and Secretary's Expenses,	200.55	200.55	
Salary—Editor's—Dr. Jackson,	1,000.00	1,000.00	
Salaries—Augusta Office:			
Dr. Carter, Secretary,	923.04	923.04	
Miss Boston,	105.00	105.00	
Salaries—Portland Office:			
Miss Gardner, Secretary,	225.00	225.00	
Mrs. Kennard, Assistant Secretary,	1,290.00	1,290.00	
Miss Hider,	12.00	12.00	
Office and Miscellaneous,	672.59	548.02	$ 124.57
Medical Advisory Committee,	500.00	500.00	
Annual Meeting,	583.15	583.15	
Clinical Session,	71.50	71.50	
A. M. A. Meeting,	76.70	76.70	
Printing and Mailing,	2,958.06		2,958.06
Plates,	112.89	112.89	
Equipment Purchased,	138.56	138.56	
1937 Expenses,	119.20	94.20	25.00
Total Disbursements,	$ 9,138.24	$ 6,030.61	$3,107.63
Cash on Hand—May 31, 1938,	$15,523.97	$14,803.06	$ 720.91
Canal National Bank—Checking Account,	$ 4,474.28	$ 3,753.37	$ 720.91
Canal National Bank—Savings Account,	2,591.07	2,591.07	
Maine Savings Bank,	4,252.00	4,252.00	
Portland Savings Bank,	4,206.62	4,206.62	
	$15,523.97	$14,803.06	$ 720.91

SECURITIES—BONDS, MAY 31, 1938

		Cost	*Market*
$2,000	Commonwealth of Australia, Ext. Loan, 30 Years, 5's, 1957,	$1,960.00	$2,150.00
700	Prudence Bond Corp., 1st Mtge. Coll., Series 6, 5½'s, 1936 (Defaulted),	700.00	200.00
3,000	Portland Terminal Co., 1st Mtge., 5's, 1961,	3,045.00	3,000.00
1,700	Mortbon Corp. of N. Y., Reg. Coll.,	1,700.00	
	$400 June 1, 1941, A 5's,		316.00
	400 June 1, 1946, B 5's,		260.00
	400 June 1, 1951, C 5's,		224.00
	500 June 1, 1956, D 5's,		270.00
10 Shares	V. T. Class A, $1 Par,		15.00
		$7,405.00	$6,435.00

* * *

County News and Notes

Androscoggin

The regular meeting of the Androscoggin County Medical Society was held April 27, 1938.

Meeting opened at 8.43 P. M. by acting president Dr. L. P. Gerrish.

Minutes of the last meeting were approved as read.

Letter from the state secretary's office requesting the men to patronize products and firms who have submitted advertisements to our state journal.

Three applications for membership were received, i. e., Drs. Gunther H. Rowe, Frederic J. Caron and Gilbert Clapperton. It was voted that they follow the usual course prescribed by the By-Laws.

On a discussion brought up regarding the disposal of the fee schedule recently drawn up, and a copy of which each member has received, it was voted that the copy could be sent to the A. M. A., which they had requested some time ago, and that a copy of the schedule in form be sent each member.

Following the conclusion of the business, Dr. Richard Dresser, eminent radiologist of Boston, delivered a lecture on "Radiological Therapy in Cancer of the Breast." His information and slide demonstrations were extremely interesting, which was followed by a lengthy discussion period.

Meeting adjourned at 10.55 P. M.

Respectfully submitted,
A. E. PETERS, M. D., *Secretary.*

Cumberland

Portland Medical Club

The regular monthly meeting was held at the Columbia Hotel, Tuesday evening, April 5th, at 8.15 P. M. Sixteen members were present.

Resolutions on the death of Dr. James A. Spalding were adopted by the Club.

Dr. Thomas Tetreau, Chairman of the Committee for the Study of Infant Mortality in Portland, the Committee appointed at the February meeting, gave a report. The conclusions were:

1. Infant deaths have decreased progressively during the last 25 years.
2. There has been practically no decrease in deaths of infants under 2 weeks.
3. There was a notable decrease in stillbirths during the 5-year period ending 1936.
4. More care in filling out death returns of stillbirths and of the newborn would materially increase their value for a study such as we have tried to make.

It was voted to retain the Committee and that this Committee report again at a later date.

The speaker of the evening was Dr. Roland Meisenbach and his subject was "The Ingestion of the Fly Larva as a Possible Cause of Infantile Paralysis, Substantiated by Experimentation on the Monkey."

ALICE WHITTIER, *Secretary.*

Portland Medical Club

The regular monthly meeting was held at the Columbia Hotel, Tuesday evening, May 3rd, at 8.15 P. M. Twenty-four members were present.

Drs. E. A. Greco, J. C. Oram and J. F. Wellington were appointed to serve as the Committee for the June Outing.

Dr. Alvin Ottum gave the paper of the evening and chose for his subject "Puerperal Infection." He dealt with the early history, bacteriology, pathology, diagnosis and treatment of this condition. He stressed the fact that the anaërobic organisms play an important part in these infections.

ALICE WHITTIER, *Secretary.*

Kennebec

A meeting of the Kennebec County Medical Association was held at the Veterans' Administration Facility, Togus, Maine, Thursday, May 19, 1938.

Clinical Session at 5 P. M. which was presided over by Samuel H. Kagan, M. D., President of the Association.

1. Plastic Repair of the Nose—H. A. Goalwin, M. D.
2. Pneumonia and Empyema—A. J. Bryant, M. D.
3. Sodomy—Harry Warshawsky, M. D.
4. Sarcoma of Tibia—J. Walsh, M. D.
5. Carcinoma of Breast of Male—Everard A. Wilcox, M. D.
6. Renal Anomalies—F. T. Williams, M. D.
7. Gastric Neurosis—Harry Levine, M. D.
8. X-ray Studies of Gastric Cases—M. T. Moorehead, M. D.

Dinner at 6.30 P. M.

Followed by a business meeting. Minutes of the last meeting were read and approved.

Burton W. Trask, M. D., of Augusta, was elected to membership.

The address of the evening was given by William A. Hinton, M. D., Chief Laboratory Department, Boston Dispensary; Chief Wassermann Laboratory, Massachusetts Department of Public Health. Subject: "Some Essential Considerations in the Diagnosis and Treatment of Syphilis". He stated that "The laboratory is an important aid in the detection of syphilis, but it is with the physician that the real responsibility lies in diagnosing the disease." He feels that the patients and doctors alike are too prone to feel that a blood test tells the whole story. "The physician", he said, "must interpret the results and use his judgment and training in the management of each individual case." Much valuable information was brought out in the discussion.

There were 48 members and guests present.

Frederick R. Carter, M. D.,
Secretary.

Piscataquis

A meeting of the Piscataquis County Medical Association was held at the Braeburn Hotel in Guilford, May 26. Dr. Samuel Proger of the Boston Dispensary spoke on Coronary Disease. His talk was considered by many as the best talk that has been delivered before our association for a long time. We hope that this will be published in the Maine Medical Journal soon so that all may have the opportunity of reading it.

At the meeting it was voted that we hold a joint meeting of Penobscot, Somerset, Kennebec and Piscataquis County Medical Associations at Moosehead Lake this summer.

Respectfully submitted,
N. H. Nickerson, *Secretary.*

York

Quarterly Meeting York County Medical Society

The quarterly meeting of York County Medical Society was held at the Henrietta Goodall Hospital, April 13, 1938. Dinner was served at 1 P. M. and the meeting was held at 2 P. M.

It was voted to recommend Drs. Weeks and Randall for the fifty-year medal.

It was voted to accept the invitation to join with Cumberland County Society for the Summer Meeting. The Fall Meeting to be held in York.

Insurance Companies were discussed and Dr. Foster, Councillor, spoke on delegates to the Convention.

Program: *What the General Physician Should Know About the Gall-Bladder*, Lester Whitaker, M. D., Portsmouth, N. H.

Resolutions on the death of Dr. Percy Abbott were read and accepted.

There were eleven members and four visitors present.

Respectfully submitted,
C. W. Kinghorn, M. D., *Secretary.*

New Member

Kennebec

Burton W. Trask, M. D., Augusta.

For Sale

Large Peroral Endoscopic Outfit and Lynch Suspension Apparatus with set of operating instruments.

Oliver W. Turner, M. D.,
Augusta, Maine.

MEMBERSHIP CARDS

Members *must* present membership cards before registering at the annual session.

Commercial Exhibits at Eighty-Sixth Annual Session

George C. Frye Co., Portland, Maine.

Visitors at our exhibit in a special room off the lobby in the Hotel Malvern will most certainly find something of interest.

Each year we plan to show you various new specialties and this year will be no exception.

Our representatives will appreciate having you call on them.

Elmer N. Blackwell, Surgical Appliance Specialist, Portland, Maine.

Doctors and their patients have need for the surgical appliance specialist. Many of the conditions encountered by the doctor can be helped and corrected by the wearing of a properly fitted appliance. Mr. Blackwell has been making and fitting TRUSSES, ABDOMINAL and BACK SUPPORTS, ELASTIC HOSIERY, and many other special appliances as prescribed or ordered, for the past twelve years. Mr. Blackwell is anxious to coöperate on any problems where supports would be beneficial and you are invited to use his mail order service. All women patients may consult with Mrs. Blackwell, who is associated with Mr. Blackwell, and who is qualified to handle any case needing an appliance. Children also are made comfortable with special designed supports. Remember the place, 207 Strand Building, Portland, Maine.

Tailby-Nason Company, Boston, Massachusetts.

"Tailby-Nason Company of Boston will exhibit Nason's Palatable Cod Liver Oil, made in the company's own plants in the Lofoten Islands of Norway, romantic Land of the Midnight Sun.

Nason's oil is prescribed and recommended by leading pediatricians from the Atlantic to the Pacific for its high vitamin potency and unusual palatability.

In addition, this old established Pharmaceutical house will display several of the most recent developments of its research and pharmacological laboratories."

Horlick's Malted Milk Corporation, Racine, Wisconsin.

Nourishing, digestible, appetizing—these are three outstanding qualities for which HORLICK'S is famous, either the powdered or Tablet form. Visit the Horlick exhibit. You will be interested in the many dietary uses—from infant feeding to old age—note especially the convenience of the Tablets, for interval feeding, in ucler diets.

Winthrop Chemical Company, Inc., New York City.

Details regarding the new specifics for streptococcus, meningococcus, gonococcus and nonspecific urinary infections, Neoprontosil and Prontylin will be available in Winthrop's exhibit. Other new Winthrop preparations to be displayed: Betaxin, Synthetic vitamin B_1; Drisdol, crystalline vitamin D_2; Evicyl, sedative-analgesic; Iocapral, vasodilator for hypertension and angina pectoris; Campolon, injectable liver concentrate.

Surgeons' and Physicians' Supply Company, Boston, Massachusetts.

"The exhibit of the Surgeons and Physicians Supply Company, Boston, Massachusetts, will be in charge of our Maine representative, Mr. Charles Joy of Lewiston, Maine. We will exhibit many new and interesting items such as Comprex Short Wave, Castle Spotlight, McKesson Pneumothor and the National Electric Body Cavity Set. We will also exhibit a line of Surgical Instruments and Comprex Catheters with many other new items."

Lederle Laboratories, Inc., 30 Rockefeller Plaza, New York City.

Lederle Laboratories, Inc., are featuring on their exhibit table a complete line of their Liver products for Oral and Intramuscular injection, together with two important new vitamin products:

Vi-Delta Emulsion Lederle containing Vitamins A and D, available in concentrated capsules as well as 8 oz. and 16 oz. bottles.

Vitamin B Complex Lederle available in 4 oz. and 8 oz. bottles.

Samples of the two vitamin products and complete descriptive literature will be available.

Petrolagar Laboratories, Inc., Chicago, Illinois.

Petrolagar Laboratories, Inc., of Chicago, will be represented by an interesting exhibit in charge of Messrs. Tarplin and Schneider.

Petrolagar is an emulsion of pure mineral oil (65% by volume) and agar-agar, accepted by the Council on Pharmacy and Chemistry of the American Medical Association for the specialized treatment of constipation. Scientific drawings and literature on the subject of constipation will be available in addition to samples of the five types of Petrolagar.

The Denver Chemical Mfg. Co., New York City.

Antiphlogistine, now in its forty-fifth year, is employed by physicians in all parts of the world in the treatment of inflammatory and congestive conditions. Physicians are invited to visit the exhibit and procure a package of Antiphlogistine, or register to have one sent.

The Coca-Cola Company, Atlanta, Georgia.

Coca-Cola will be served to the delegates with the compliments of The Coca-Cola Company.

J. B. Lippincott Company, Philadelphia, Pennsylvania.

J. B. Lippincott Company will display NEW books: Bacon-Anus, Rectum and Sigmoid Colon; Thorek-Modern Surgical Technic; Kracke-Diseases of the Blood and Atlas of Hematology; Wilson-Fractures; Wolf-Physician's Business . . . and New Editions of old favorites: McBride—Disability Evaluation; Rehberger—Quick Reference Book of Medicine and Surgery; Thorek—Surgical Errors and Safeguards; and Means—Thyroid and Its Diseases. See also the NEW International Clinics edited by Dr. George Morris Piersol.

Mead Johnson & Company, Evansville, Indiana.

Mead Johnson & Co. will exhibit their complete line of infant diet materials, including the latest developments in the field of infant nutrition. A representative will be on hand to discuss any point regarding these materials which may come to the physician's mind.

The P. J. Noyes Company, 51 Main Street, Lancaster, New Hampshire.

The 1938 meeting of the Maine Medical Association affords us the opportunity of contacting old friends as well as new ones, and the chance for contributing in a modest way to its success.

Joe E. Brown, Representing
The P. J. Noyes Company.

The Thomas W. Reed Company, Boston, Massachusetts.

The Thomas W. Reed Company of Boston, Mass., are pleased to announce that at the coming Maine Medical Convention, Mr. J. F. Walsh will be in charge of the display.

The latest type of Short Wave Apparatus, Pedestal Operating Tables and Portable Operating Lights will be exhibited, in addition to many other items, particularly interesting to Physicians.

Picker X-Ray Corporation, 920 Beacon Street, Boston, Massachusetts.

The Picker X-Ray Corporation, Boston, Massachusetts, is pleased to announce that the equipment to be displayed at the Maine Medical Association Convention will include the New Picker-Waite Simplified Portable X-Ray Unit and other accessories featuring Keraphen (standard gall bladder dye), Basolac (for gastro-intestinal examination), Picker lead rubber gloves and fluoroscopic goggles.

As one of the largest manufacturers of X-Ray apparatus exclusively, we are very happy to appear at the Maine Medical Association Convention in the interest of X-Ray therapy and radiographic advancement. We cordially invite you to our booth in Exhibition No. 2.

H. G. Fischer & Company, Chicago, Illinois.

The latest Fischer Model of Short Wave, X-Ray and other apparatus, to be exhibited and demonstrated by H. G. Fischer & Company, will interest physicians because of their many unique features of design and performance. The complete Fischer line includes Shockproof X-Ray Apparatus, Short Wave Units, Combination Cabinets, Galvanic Generators, Ultra-Violet and Infra-red Lamps; Tissue-cutting and other units, accessories and supplies. Physicians attending the convention are invited to ask for demonstrations of models in which they are interested or to consult with Fischer representative regarding technics made available by Fischer apparatus.

General Electric X-Ray Corporation, 620 Beacon Street, Boston, Massachusetts.

In addition to displaying its redesigned, higher powered portable shockproof X-Ray unit, the Model F3, which every physician should see and inspect, the General Electric X-Ray Corporation will show the light-weight low-cost electro-cardiograph already famous for its consistant accuracy and dependability, and the Inductotherm which, by electromagnetic induction, generates heat within the deep tissues for local application or therapeutic fever.

Wherever shown, the G-E Model F3 X-Ray unit is favorably commented upon for its compactness, flexibility, and wide range of service which it provides. For its size, it is the most powerful apparatus ever built and answers ideally the X-Ray needs of the average physician.

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M & R Dietetic Laboratories, Inc., Columbus, Ohio.

"Similac, a Council-Accepted diet for infants will be on display. This product is a completely reconstructed powdered milk which was developed at the Boston Floating Hospital. When reliquified in proper proportions, the resulting milk is of the same percentage composition as the average breast milk and has the same zero curd tension. Messrs. John J. Krancer and Arthur M. McCormick will be present to furnish interesting details."

H. P. Hood & Sons, Charlestown, Massachusetts.

The exhibit of H. P. Hood & Sons will portray the control exercised over the production, handling and delivery of their various grades of milk. Special stress will be placed on the methods and standards for Certified Milk production as carried on at Cherry Hill Farm.

John Wyeth & Brother, Inc., Philadelphia, Pennsylvania.

John Wyeth & Brother, Incorporated, will display a number of their pharmaceutical specialties, including:—Kaomagma, intestinal absorbent; Amphojel, Wyeth's Alumina gel, antacid; Silver Picrate, "accepted" for use in the treatment of Trichomonas vaginitis; Bewon Elixir, a palatable dosage form of crystalline Vitamin B_1, and other newer preparations of interest to both general practitioner and specialists.

E. R. Squibb & Sons, 745 Fifth Avenue, New York City.

Physicians attending the Maine Medical Association convention are cordially invited to visit the Squibb Exhibit in Parlor K. The complete line of Squibb Vitamin, Glandular, Arsenical and Biological Products and Specialties, as well as a number of interesting new items, will be featured.

Well informed Squibb Representatives will be on hand to welcome you and to furnish any information desired on the products displayed.

Jenkins Laboratories, Inc., Auburn, New York.

Mr. J. H. Gallagher, our Maine representative, will be pleased to greet our many friends at the convention, and display our line of fine pharmaceuticals.

E. H. Marcy Drug Co., Hillsboro, New Hampshire.

Over the head of every practicing physician and surgeon hangs the threat of a suit for

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*Approved and accepted by the Council of the Maine Medical Association.

Book Review

"Management of the Sick Infant and Child"

By Langley Porter, B. S., M. D., M. R. C. S. (Eng.), L. R. C. P. (Lond.), Dean, University of California Medical School and Professor of Medicine; formerly Professor of Clinical Pediatrics, University of California Medical School; Visiting Pediatrician, San Francisco Children's Hospital; Consultant to the San Francisco Department of Public Health, San Francisco, Calif.; and William E. Carter, M. D., Director, University of California Hospital Out Patient Department; formerly, Chief of Children's Clinic, University of California Hospital, San Francisco; Attending Physician, San Francisco Hospital; Attending Physician, Los Angeles County Hospital, San Francisco, Calif.

Published by The C. V. Mosby Company, St. Louis, 1938. Price, $10.00.

In this, the fifth edition, the authors have incorporated methods of management applicable to older children as well as to infants. The contents of this very worthwhile book are divided into three major parts. Part One deals extensively with vomiting, diarrhea, constipation, nutrition, hemorrhage, pain and tenderness, convulsions and syncopes, fever, cough, and prematurity. Part Two thoroughly discusses diseases of the respiratory tract, digestive tract, heart and circulation, blood and lymphatic system, behavior, skin diseases, allergy, genito-urinary diseases, diseases of the osseous system, and of internal secretions, and infectious diseases. Part Three describes methods of treatment, gives formulas and recipes, enumerates drugs according to their applicability in certain diseases and ends with a chapter on treatment of poisoning.

The authors appear considerably enthused over their success in treating streptococcal infections with sulfanilamide and give fairly extensive directions for its proper use. There are ninety-four excellent illustrations, most of them are incorporated in the section on methods, and illustrate the proper instruments, position of patient, nurse and physician, and the various steps in the carrying out of the various methods of treatment are fully described.

This work ought to prove a welcome addition to the literary armamentarium, especially of those physicians practicing in the country and who are not in close physical relationship with the larger medical centers.

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Convention Rates

The Malvern

The management of The Malvern Hotel, Bar Harbor, Maine, has been pleased to quote the following rates for members of the Association in attendance at the annual meeting, June 26th, 27th and 28th. These rates include all meals and banquet. Reservations will be made in order of their receipt by the hotel. Members are asked to write The Malvern Hotel direct, making whatever reservations they desire.

Single room with bath	$8.00 per day
Double room with bath and single beds, each person	$8.00 per day
* Two double connecting rooms with bath and single beds, four persons, each	$7.00 per day
Single room with running hot and cold water	$7.00 per day
Double room with running hot and cold water, with single beds, each person	$6.00 per day
Cottage	$8.00 per person

Charges for meals to one not having a room:

Breakfast	$1.00	Dinner	$2.50
Luncheon	$2.00	Banquet	$2.50

The daily rate includes the banquet, providing guests remain one full day.

* In-as-much as double rooms with bath are limited but double connecting rooms with bath are available it is suggested that groups of two members and wives apply for double connecting rooms. Also note that cottages are available to larger groups.

Belmont Hotel

The management of the Belmont Hotel, Bar Harbor, Maine, has been pleased to quote the following rates for members of the Association in attendance at the annual meeting:

Double room, twin beds, private bath, each person	$6.50 per day
Single room, private bath	$7.00 per day

These rates include meals.

Make Your Reservations Early!!

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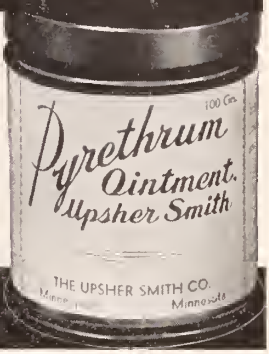

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Medical Director

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MAINE MEDICAL ASSOCIATION

Volume Twenty-nine   July, 1938   Number Seven

BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

V. HEAT PROCESSING THE SEALED CONTAINER

● Previously, we have described how raw food material is sealed in the tin container after proper preparatory treatment. After sealing, the next important step in commercial canning is the heat process, or "process" as it is called in the industry.

Essentially, the processing operation involves exposure of the sealed container to hot or boiling water, or to steam under pressure, for the correct period of time. The purpose of the process is to destroy pathogenic or spoilage organisms which may be present on raw food material; the seal on the can then prevents re-infection of the foods by such organisms. Thus, the sealing and processing operations combine to insure a sound, wholesome canned product.

It is not possible here to review all factors which must be considered in the establishment of an adequate heat process for any specific product. Such factors have been briefly discussed in recent publications (1, 2). It must suffice to state that, in general, commercial processing operations are divided into two general types, depending upon the acidity of the food being canned.

The "acid" foods—including the common fruits and certain vegetables or vegetable products whose pH values fall below 4.5—are quite easily heat processed. With such foods it is only necessary to heat the sealed container long enough to permit the attainment of a definite temperature in the center of the can (usually 200°F. or slightly less). In fact, some acid products may be processed by filling sufficiently hot, sealing and inverting the cans, and cooling without further process.

The "non-acid" foods—such as meat, sea foods, milk and most of the common vegetables—require temperatures above that of boiling water for adequate heat processing. Such foods are processed under steam pressure in a closed "retort", usually at a temperature of 240°F. Years of research have made possible the issuance for the guidance of modern canners of a bulletin listing recommended process schedules for the non-acid products (3).

Regardless of the temperature of processing, equipment is available which permits use of the batch or "still" process, and the "continuous" or "agitating" types of process for sealed cans. Improvements in processing machinery and accessory instruments during the past two decades permit precise, scientific control of commercial processing operations.

Above all, however, the modern canner has a clear understanding of the underlying purpose of the process and a deep appreciation of the necessity for strict supervision of the processing operation. Commercially canned foods, consequently, must be ranked today among the most wholesome foods coming to the American table.

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(1) 1938 Food Research 3, 13.

(2) 1937. J. Amer. Med. Assn. 109, 1046.

(3) 1937. Natl. Canners Assn. Bull. 26L, 3rd ed.

This is the thirty-eighth in a series of monthly articles, which summarize, for your convenience, the conclusions about canned foods reached by authorities is nutritional research. We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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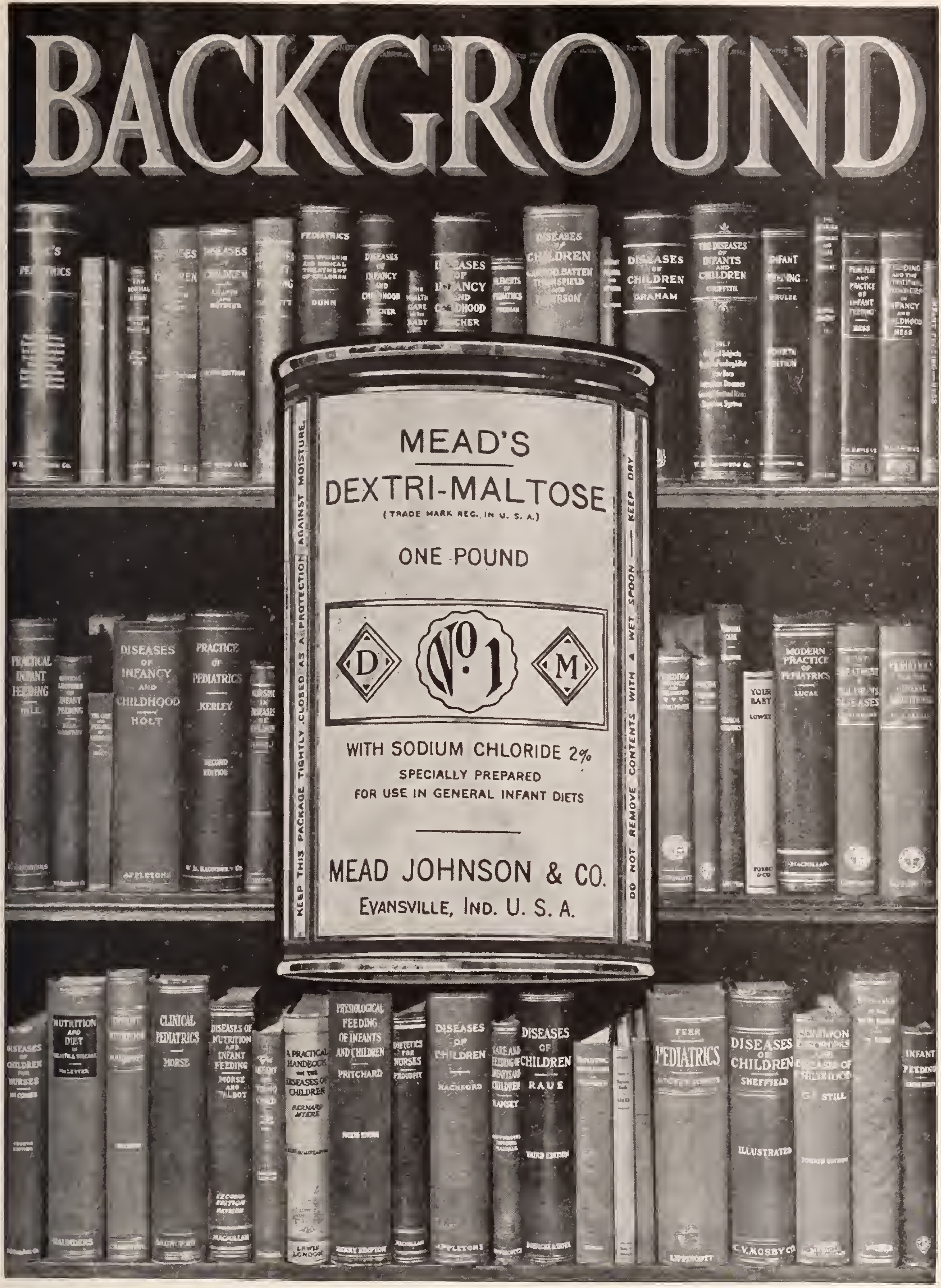
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Maine Medical Journal

The Official Organ of

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Vol. XXIX *Portland, Maine, July, 1938* *No. 7*

President's Address

By R. W. Wakefield, M. D., F. A. C. S., Bar Harbor, Maine

Endometriosis and Endometrioma

Pelvic endometriosis is a disease so serious that it merits our earnest consideration, yet the textbooks on Gynecology hardly mentioned the condition until only within the past two decades.

Sampson's brilliant paper published in 1921 first gave the disease the importance it deserves and since that time many of the leading gynecologists have made careful studies of the condition and reported cases, notably Cullen and Novak.

It is only within very recent years that the general surgeon has become interested and rightly so.

This is not a rare disease, as some might lead you to believe.

Sampson claims it occurs in 45% of his pelvic cases, but this percentage is much higher than is reported by most gynecologists.

In a personal talk with Dr. Watson, chief gynecologist at the Sloan Hospital, Medical Center, New York, he estimated these cases constituted about 15 to 20% of his pelvic cases and this is about the average of most operators.

There is no more interesting chapter in the whole history of gynecology than the recognition and study of pelvic endometriosis.

To the pathologists belongs the credit for the first recognition of the disease.

It was noted that certain myomata of the uterus contained glandular tissue and hence these tumors were named adenomyoma. These adenomyomata differed in two respects from the myomata other than containing glandular tissue, viz: first, instead of staying within their own capsule and pushing adjacent tissue ahead of them as they enlarged, they broke through their capsules and invaded adjacent organs and became a part of them.

Second, this disease is not confined to the uterus, but may involve any of the pelvic organs, including the sigmoid colon and, in fact, may extend as high as the umbilicus. It may involve an abdominal scar subsequent to a pelvic operation.

I have lantern slides showing involvement of the appendix and terminal ileum.

For a long time it was a mystery how this glandular tissue from the endometrium could appear in these tumors of the uterus except those adjacent to the endometrium and, stranger still, how this tissue could appear in an organ in no way connected with the uterus.

Sampson claimed in his paper that the

endometrial tissue was extruded through the Fallopian tubes at the time of menstruation, especially if there was some atresia of the cervix, and that this tissue adhered and developed on whatever organ it happened to strike, the most common, of course, being the ovary, broad ligament and uterus.

Some research workers, notably Novak, claims this is a heteroplasia.

The embryonic tissue lies dormant until the ovaries begin to function and then development begins.

Probably both theories are correct since some cases are accounted for best by Sampson's theory and some by Novak's.

This tissue has all the morphological characteristics of the endometrium and, besides, it menstruates wherever it happens to be.

When it involves the ovary, as it does more often than any other organ, a cyst is usually formed and the contents of the cyst consists of the bloody exudate from this tissue, hence the chocolate cyst of the ovary, now called endometrial cysts.

This bloody exudate leaks through the cyst wall carrying with it endometrial cells and wherever gravity happens to take this material that organ becomes involved, the most common being the broad ligaments, uterus and sigmoid colon. If it falls to the bottom of the pelvis it forms dense adhesions with the posterior surface of the uterus pulling the organ in sharp retroversion.

In fact, sometimes this endometrial tissue will develop so extensively in the pelvis that it will fuse all the organs in one solid mass and upon examination one will find a "frozen pelvis."

When this tissue invades the intestinal wall, it causes a weakening of the structures and leaking of the intestinal contents may take place at the time of operation and peritonitis will develop.

This is an important point in the consideration of treatment.

Symptoms

Pelvic endometriosis occurs in women between the ages of twenty and forty-five, in other words, during the period of the greatest ovarian activity.

Pain and sterility are the greatest complaints.

Some cases are so mild and slow in development, no symptoms are produced and the condition is found when the abdomen is opened for some other reason.

On the other hand, small invasion of endometrial tissue may cause severe pain and the patient will seek early relief.

The pelvic pain is, more or less, constant and increases in intensity during the menstrual period and throughout the period.

In ordinary inflammation pain usually diminishes as the menstruation is established.

If the sigmoid is involved, there is pain in this region with gaseous distension, constipation and obstipation, which may go on to intestinal obstruction.

Diagnosis

When a woman between the ages of twenty and forty-five, in whom no history of puerperal or gonorrheal infection can be obtained, presents herself and who complains of pelvic pain which is intensified at the time of menstruation and when, upon examination, you find a "frozen pelvis," or if the disease is not so far advanced, you find a cystic ovary and dense nodules can be palpated along the sides of the uterus, in the broad ligaments and perhaps the sigmoid colon, it is fairly reasonable to assume you are dealing with a case of pelvic endometriosis.

Usually, however, the diagnosis is made after the abdomen has been opened for some other reason.

Strange as it may seem, not a large percentage of gynecologists and few general surgeons are alert to this disease.

Treatment

The treatment of pelvic endometriosis is essentially surgical; first, to remove the tumor mass that usually causes severe pain by pressure on the pelvic nerves and, second, to resect both ovaries, since this procedure stops the progress of the disease.

Irridation to stop ovarian activity, to my mind, is not so good as operation, for two reasons: first, because the tumor mass should be removed to relieve the pain and, second, to eliminate the possibility of malignancy.

Irridation is indicated in the "poor risk" case because it will help the pain and stop the ovarian function.

When post-operative activity occurs deep X-ray therapy is indicated.

I know of no cases more prone to post-operative complications.

The more common are shock from hemorrhage, ileus, nausea, vomiting and peritonitis.

When the sigmoid is involved in the ordinary pelvic inflammation, it is usually easily separated from the adjacent organs, but in endometriosis there is an ingrowth of the tissue into the intestinal wall extending to the lumen, so that when one attempts a separation, a perforation will often result.

A fecal fistula is always a surgical misfortune.

Even when the cleavage is made through the endometrial tissue, there may be leakage from the bowel and peritonitis will follow.

When extensive adhesions have been separated and, especially, when there is bowel involvement, these cases should be drained.

◆

*Acute Lymphocytic Meningitis and Other Virus Diseases of the Central Nervous System**

By Henry R. Viets, M. D., Massachusetts General Hospital, Boston

We are passing through an age of bacterial disease into an age of virus disease. This is shown not only by the vast literature on virus diseases which is to be found in current periodicals but also by the increase in the numbers and variety of virus maladies reported. It is now known, or strongly suggested, that the following diseases are caused by viruses: smallpox, rabies, herpes simplex, yellow fever, varicella, herpes zoster, mumps, poliomyelitis, common colds, encephalitis in many of its various forms, influenza, measles, German measles, acute lymphocytic meningitis and possibly multiple sclerosis, neuro-optic myelitis, Schilder's disease, and a number of diseases in animals, such as foot-and-mouth disease of cattle, hog cholera and canine distemper. Some of these diseases have been transmitted experimentally through laboratory animals; in others the virus is characterized by its filtrability, or its power to form inclusion bodies in the cells which it attacks. On these findings the viruses are classified.

VIRUSES IN GENERAL AND THOSE SPECIFICALLY AFFECTING THE CENTRAL NERVOUS SYSTEM

The nature of no virus is definitely known [1 2]. We do know, however, that they are smaller than ordinary bacteria and that they have not been cultivated in vitro in the absence of living susceptible cells. It is believed that they multiply or regenerate within such cells, a point not without clinical significance. If their action be slow, in a cell capable of multiplication, hyperplasia may result. Such hyperplasia may be followed by destruction, as in smallpox. When the action is rapid, necrosis only takes place, a result seen in yellow fever. If the cells have no power of regeneration, such as nerve cells, lysis occurs without possibility of restoration of function. Poliomyelitis and rabies are good examples of this type of degeneration.

Those viruses particularly affecting the central nervous system are conveniently classified on the basis of the part primarily attacked[3 4]. Certain viruses appear to have an affinity for nerve cells and fall into a group, "obligatory neurotropic" in character. Four well-known diseases are caused by viruses of this type: poliomyelitis, encephalitis, rabies and herpes zoster. In all, the virus causes destruction of parenchymatous nerve tissue without affecting other parts of the body. On the other hand, viruses affecting the body apart from the nervous system may also, under certain circumstances as yet not clearly understood, become neurotropic and cause central nervous system disease. This occurs in yellow fever and influenza in man and in equine encephalitis in animals. Bacteriologically such viruses are examples of "facultative neurotropic" action. As the attack occurs, too, on nerve cells, permanent destruction is often evident clinically. The latest neurotropic virus to be discovered affects particularly the meninges and is the main thesis of this paper.

---

* Read at a meeting of the Cumberland County Medical Society, Portland, Me., April 22, 1938.

Finally, there are some viruses not primarily destroyers of nerve cells or affecting the meninges, but whose presence is detected by loss of the myelin covering of axones within the nervous tissue. This process of demyelinization is found in the clinical conditions of encephalomyelitis, postvaccinal and postantirabic encephalitis, the brain destruction following chicken pox, smallpox, measles and mumps, and possibly in multiple sclerosis, neuro-optic myelitis and Schilder's disease.

There have been, moreover, many as yet unclassified epidemics of nervous disorders, probably due to viruses. The condition described as epicranial paresthesia[4a] may be of this type, as well as polyneuritis with facial diplegia, retrobulbar optic neuritis, some forms of myelitis and other transient disorders affecting the central nervous system. The virus etiology of none has been established. One disease, however, formerly suspected of being a virus disease and now clearly established as such, is acute lymphocytic meningitis.†

ACUTE LYMPHOCYTIC MENINGITIS

The disease, first clearly described as occurring in children by Wallgren[5] of Gothenburg in 1925 and long called *acute aseptic meningitis,* was considered a possible clinical entity by him and in 1929 by Viets and Watts[6], who reported the first cases in this country. Before the discovery of the virus, the clinical aspects of the disease were farther elaborated wth a review of the literature.[7] At the same time, one fatal case was described with the pathological changes in the central nervous system[8]. Without virus proof the case cannot be unqualifiedly accepted as an example of acute lymphocytic meningitis and therefore the changes found are not necessarily those compatible with the disease in humans. It is somewhat remarkable that no fatal case has occurred (excepting the one described above) in man in a disease often causing death in the experimental animal.

Clinically[7] the disease is characterized by a mild to moderately severe acute meningitis with a strongly lymphocytic cerebrospinal fluid formula, without marked decrease in sugar or chloride content. The disease is self-limited and seldom, or perhaps never, results in late manifestations. Occasionally cases of considerable severity are seen[8], with cells in the fluid mounting to nearly 4000 per cubic millimeter. In the milder cases the cells are few in number and exclusively lymphocytic; in the more severe cases there is a great increase in cells and polymorphonuclear leucocytes are frequently seen. The presence of these latter cells indicates the severity of the illness and their reduction in number and final disappearance is coincident with recovery.

The most important finding in the cerebrospinal fluid is the practically constant sugar and chloride content. This is in marked contradistinction to the findings in tuberculous meningitis and is the chief laboratory test which is helpful in the differential diagnosis of the two diseases. When these tests are not done, the diagnosis in the early stages of the disease is always doubtful. In the literature, moreover, practically all cases have been considered tuberculous meningitis until proved otherwise. In a very severe case the sugar may fall as low as 40 mg. per 100 c.c., a finding suggestive of tuberculous meningitis. Occasionally there is found, in addition, in the cerebrospinal fluid a fibrin clot or pellicle, which appears after the fluid has stood for twelve to twenty-four hours. This appearance, formerly thought to be indicative of tuberculous meningitis, can no longer be considered so. Organisms are never found in the cerebrospinal fluid and the fluid, when injected into guinea pigs, gives a negative test. The Wassermann reaction is always negative.

---

† Although marked changes have been found in the choroid plexus in animals affected with this disease, resulting in the use of the term *acute choriolymphocytic meningitis,* choroid changes are as yet unproven in man. It seems best, therefore, to use the more simple name, *acute lymphocytic meningitis,* in the clinical description of the disease.

Other laboratory data are also negative. There is a slight elevation of the white blood cell count to 10,000 or 11,000. Blood cultures show no growth and the Widal test is negative. The blood, moreover, may show strongly protective antibodies against this disease. These antibodies appear within four to six weeks and may continue to be found in the blood, in our experience, for over two years after the initial disease.

There have been no late manifestations in our series and most of our patients seen in 1929 are symptom-free in 1938. Some reports from the literature do not indicate such good results. Two patients have shown a change of disposition and one developed strabismus[9]. It is possible that these were not correctly diagnosed, for they were patients seen before our knowledge of the virus as the cause of the disease.

The epidemic character of the disease is suggested but not proven. In general, acute lymphocytic meningitis tends to appear in the early spring or late summer or autumn; it is probably most prevalent in August and September and is definitely not a winter disease.

The virus causing this rather rare syndrome was first identified by Armstrong and Lillie in 1934[10]. Subsequently a similar virus was reported by Traub[11], by Rivers and Scott[12], and by Findlay, Alcock and Stern[13]. There appears to be a close connection between the viruses established by these four sets of investigators. Each virus has been checked against that of Armstrong. In white mice the disease causes a characteristic syndrome with pathological changes in the meninges and in the choroid plexus.

No proven case of this disease has been described pathologically in man. Viets and Warren[8] made a post-mortem examination of a man of twenty, who, dying on the eleventh day of his disease, had the symptoms associated with acute lymphocytic meningitis. This case ocurred, unfortunately, before the authors knew of the identification of the virus, which had occurred a few months previously. The patient's blood, therefore, was not tested for antibodies, nor was the spinal fluid used for virus identification. In view of this, we cannot entirely accept this case as one of acute lymphocytic meningitis. The findings, moreover, were those of a disease not confined to the meninges, for there were lesions widespread throughout the central nervous system and encephalitis, as well as meningitis, was well marked. Although the nervous tissue reaction was a severe one, from the pathological appearance the authors felt that the changes did not necessarily preclude recovery. The chief findings were œdema of the meninges and cortex, with cellular infiltration along the vessels and into the cerebral tissue and large granulation cells in the mid-brain, showing inclusion bodies and pigmented granules. This condition is one seen in other types of known virus disease.

Conclusions

Acute lymphocytic meningitis appears to be a clinical identity, with a known virus as its cause and a clinical course which justifies its being described as a separate disease. It is probably, however, closely allied to other virus diseases of the central nervous system, such as retrobulbar optic neuritis, myelitis, encephalitis, herpes zoster, and possibly poliomyelitis. There are, moreover, types of peripheral neuritis which are closely related to this syndrome. Patients have been known to exhibit, at various times in the course of their illness, such a variety of symptoms as retrobulbar neuritis, peripheral neuritis, and transverse myelitis, as well as signs of encephalitis and meningeal reaction.

Although the disease was first described by Wallgren in 1925, it was not until 1934 that the etiology was found. In the meantime, however, many clinical descriptions had been given and the disease was coming to be recognized in hospitals. In the last four years a large number of cases have been reported and gradually we are learning something about a new disease, fortunately characterized by a benign symptomatology and lack of late manifestations. Thus it is distinctly different from encephalitis of the epidemic type or poliomyelitis.

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*Laurence-Moon-Biedl-Syndrome—Report of Two Cases**

By L. A. Parrella, M. D., Lewiston, Maine

Seventy-three years ago Laurence and Moon first noted a combination of symptoms comprising obesity, hypogenitalism, mental deficiency, polydactylism and pigmentary disturbances of the retina. Biedl emphasized the familial nature and the fact that this combination makes a unit syndrome. It was first described in this country by Solis-Cohen and Weiss, who gave it the name of Laurence-Moon-Biedl Syndrome. Since that time over a hundred cases have been described which have been classified, according to the number of the five cardinal symptoms present, into complete, incomplete, and the "supercomplete" (the latter being the ones that had additional developmental anomalies or physical defects).

There has been much speculation concerning the etiology of this condition. Biedl[4] in 1933 said that contrary to belief it was not a primary disorder of the hypophysis. He said that it may be assumed that the simultaneous occurrences of disturbances in the mesencephalon and other areas is the result of the common derivations of these regions from the primary anterior vesicle. Cooperstock[1] says, regarding the pathology, that the hypophysis and the hypothalamus have been implicated without substantiation. Cockayne[2] postulated that the symptoms of the Laurence-Moon-Biedl Syndrome result from hereditary developmental disturbances and that various parts of the syndrome represent mesoblastic (polydactylism) and epiblastic (obesity, retinitis pigmentosa, mental inferiority and genital dystrophy), defects which are recessive and are due to mutations of two genes in the same chromosomes.

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* From Pownal State School. First seen and diagnosed at the Mental Hygiene Clinic of Bangor State Hospital.

The familial factor has been stressed by several writers (Cooperstock[1], Molitch[3]). Molitch[3] says that isolated cases without other siblings having the condition and not showing all the cardinal symptoms should not be included as being Laurence-Moon-Biedl Syndrome cases. On the other hand, Warkany, Frauenberger and Mitchell[8] in an article in which they reported four incomplete cases of Laurence-Moon-Biedl Syndrome doubted the existence of the syndrome altogether. They tabulated all the reported cases and showed that there were only ten "real complete" cases of the disease and concluded that the observers had been influenced by some special phase of heredo-familial deviations, as well as by chance, and had, therefore, erroneously decided that they were dealing with a new disease entity.

The type of obesity seen in the Laurence-Moon-Biedl Syndrome is of the Fröhlich type. The visual disturbance in these cases appears early in life and only occasionally at five years or later. Though the retinal degeneration is constant, the character of the pigmentary disturbance, however, varies. The "bone corpuscle" type of pigmentation along the retinal vessels at the periphery is seen infrequently. Atypical forms are far more common. Polydactylism is found in one or all the extremities symmetrically or asymmetrically and may vary in location and structural type. According to Cooperstock[1] and Cockayne[2] more than one extra digit has not been reported on either hand or foot. Levingstone[7] has lately reported a case where seven digits were present on each hand. These extra digits are always postaxial in position, that is, they are situated towards the little finger and may vary from just a fibrous nodule representing the digit to a well-formed digit. Syndactylism has been reported either in addition to or in the absence of supernumerary digits. Mental inferiority rarely develops in a child whose mental progress has been normal but becomes apparent in patients more usually early in life. Occasionally just a mild deficiency may be present, but it is rarely absent. Genital hypoplasia has been in some instances reported absent but, when found, it varies in degree.

Numerous other conditions have been seen associated with this syndrome, such as: nystagmus, deafness, shortness of stature, deformity of the skull, abnormal shortness of the hands and feet, irregularity of the toes, genu valgum, scoliosis, congenital heart disease, bilateral coxa plana, and anal atresia. Laboratory findings show nothing abnormal, that is to say, there are no constant variations of basal metabolic rates, blood chemistry determinations, blood counts, urinalyses, skull X-rays, etc.

The prognosis as to length of life in individuals having the syndrome is good, but it is generally agreed that there is never much improvement. One case has been recorded of a person who lived to be over seventy years of age.

The treatment of these cases is generally conceded to be ineffectual with several exceptions. Reilly and Lisser[10] report that two of their cases responded well to endocrine therapy. They noticed weight loss, increased animation and a definite improvement in vision. Bing[9] treated his two cases with calcium, thyroid and pituitary extract and noted loss in weight, rise in basal metabolism, change from dullness and apathy to animation and interest in their surroundings but was able to find no effect on the vision.

It is the purpose of this paper to report two more cases of Laurence-Moon-Biedl Syndrome. They are two brothers, one nine and the other twelve years of age. Two other siblings, now dead, in the same family were said to have had the same condition.

CASE REPORTS

Family History: The paternal grandfather and grandmother were both of French-Canadian extraction and attended common school. They had no mental or physical defects as far as is known. The paternal grandfather, a farmer, died of heart disease at the age of seventy-eight, and the paternal grandmother died of cancer at the age of sixty. The maternal grandparents were also of French-Canadian extraction and showed no peculiarities or defects. The maternal grandfather, a common laborer by occupation, died of a stroke at the age of sixty-three years. The maternal grandmother, who was a school teacher before her marriage, died at the age of forty-six during her menopause, cause of death not given. No mental abnormalities were present in any of the other relatives. The patients' father, a farmer by occupation, is a large man and has no mental defects. He is said to be in good health, and was in good health at the time of the birth of both of these children. The mother is a housewife by occupation, normal mentally and physically. She has given birth to six children, four of whom are living and only two of whom have been normal. There is no blood relation between parents. The siblings include: two brothers apparently normal, one sixteen years old and the other seven years old; one brother who died at the age of eight of meningitis and one sister who died at the age of five months of "cholera morbus," both of whom were said to have the same peculiarities characteristic of this syndrome; and Clifford and Willard, the subjects of this report.

CASE ONE

Clifford is a twelve-year-old boy who was fourth in the order of birth. He was a full-term five-pound baby, whose delivery as far as is known was normal. His first teeth erupted at eight months and he did not walk alone until he was eighteen months. When he was three years old he could speak in short sentences, but he has never been able to carry on a conversation. He can feed himself but has always required help in dressing. At the age of six he became tidy in his habits. The only childhood disease given is measles. The mental peculiarities were first noticed when Clifford was four years old, because he had been late in learning to walk and did not talk as much as other children of his age. He was sent to school at the age of five years and attended for seven years, never going beyond the first grade. Clifford can neither read, write, nor do simple arithmetic. The home environment has been good and the influence of the parents has been good. Clifford has not been guilty of any misdemeanors although he does not take kindly to correction.

Since admission he has behaved himself quite well. The patient is very sluggish in his movements and remains quietly wherever he is placed. His attitude towards other patients tends to be affectionate, although usually he is unaware of his environment unless the person addressing him is quite close. He speaks English only in short sentences. Although tidy in his habits, he is careless about his eating and his clothing is always stained with food.

Physical Examination: Clifford is a very obese, twelve-year-old boy with a stupid, apathetic, adenoid, facial expression. He is 59½ inches tall (151 cm.), weighs 173 pounds (69 kilos), his chest measurement is 38½ inches (98 cm.), while his waist measurement is 43 inches (109 cm.). His hair is brown, complexion light and the eyes are blue. The head is symmetrical but shows some acrocephaly and a slightly receding forehead. The palpebral fissures are small and reveal eyeballs of moderate size and pupils that are regular and react to light and accommodation. Ophthalmoscopic examination shows optic atrophy and retinal degeneration but no "bone corpuscle" type of pigmentation is present. Further examination to determine the patient's vision and extent of his visual fields was impossible because of lack of coöperation. The nasal septum deviates slightly to the left. Inspection of the mouth shows a large lower lip, a small tongue which protrudes in the median line with no tremors, teeth regular in shape and arrangement with several caries. The soft palate is normal, while the hard palate is high and V-shaped. The throat shows tonsils which are markedly enlarged. The thyroid gland is not palpable. Examination of the chest reveals large breasts, equal and regular expansion with physiological breath sounds. The heart borders cannot be percussed very well, nor can any murmurs be made out. Its action is slow with a rate of only 58 and the sounds are distant. The blood pressure is 112/76. The abdominal wall is very obese and pendulous. No viscera can be palpated. The penis is very small, while the testicles are small and not completely descended. No abnormal reflexes are present. Examination of the right hand shows seven digits, while the left hand shows six digits and one digit nodule (the supernumerary digits are postaxially located). There are six toes on each foot and the supernumerary digits are likewise postaxial in their location. The fifth toe of the left foot crosses over the fourth. Bilateral pes planus and genu valgum are present. The tonicity of the muscles is fair. An uncertainty of the gait is noted, such as would be consistent with a patient having defective vision. The skin is dry and leathery and the nails are thin and short. The hair on his scalp is fine and dry and it appears sparsely on the arms but is absent in the axillæ and groin. Adiposity of the Frölich type is evident in large amount over the shoulders, girdle and thighs and the abdomen, which is particularly obese and pendulous.

X-ray Findings: Roentgenograms of the hands show normal ossification centers with the epiphyses still ununited as one would expect to find in a boy of his age. The fourth metacarpal of the left hand bifurcates, giving rise to the fourth and fifth fingers. In the digit nodule of this hand two small bones are seen. The fourth finger of the right hand has the normal number of phalanges which arise from a very rudimentary metacarpal only 1.9 cm. long. The metacarpo-phalangeal joint of this digit is in close approximation to that of the fifth finger. The seventh digit of the right hand contains two small bones which also do not appear to have any articulation with any other bone.

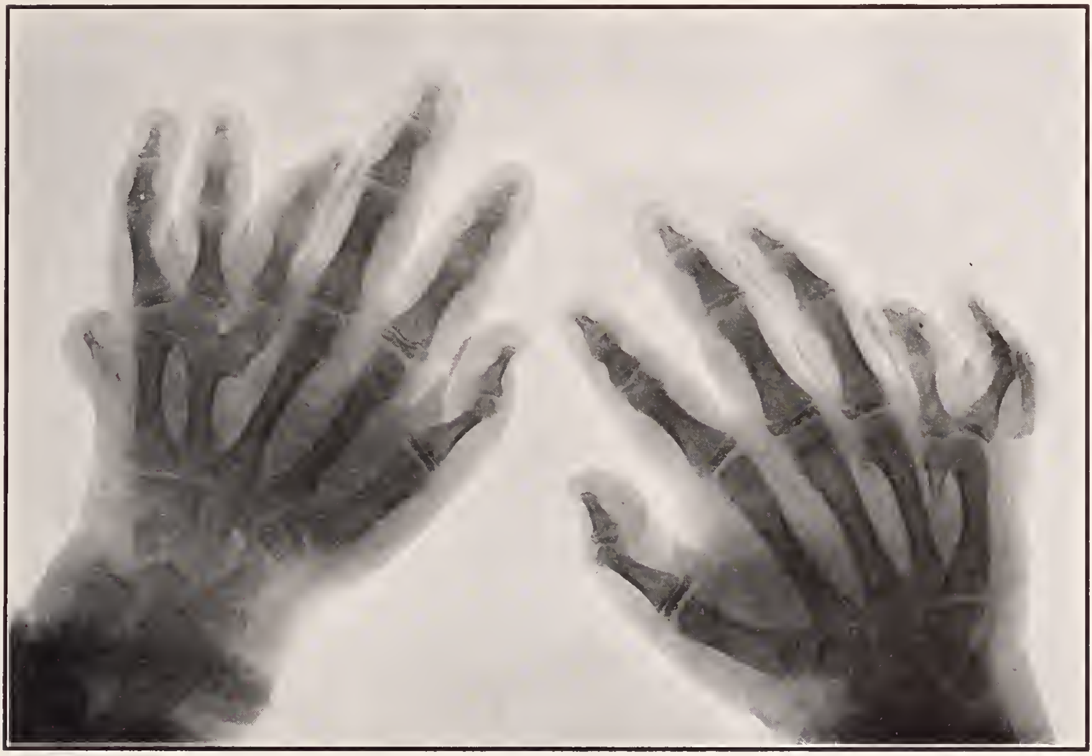

Figure 1, X-ray of Clifford's hands.

Measurements of the fingers of Clifford's hand are tabulated because of the differences between hands. They were taken on the roentgenogram.

MEASUREMENTS OF CLIFFORD'S FINGERS

	Right	*Left*
1st	4.5 cm.	4.5 cm.
2nd	6.2 cm.	6.2 cm.
3rd	7.3 cm.	7.3 cm.
4th	6.7 cm.	5.1 cm.
5th	4.8 cm.	5.7 cm.
6th	4.5 cm.	5.7 cm.
7th	1.9 cm.	2.5 cm.

There is a bifurcation of the fifth metatarsal about midway in the right foot, giving rise to the sixth toe which contains two phalanges. On the left, however, the fifth and sixth toes both articulate with the fifth metatarsal. The overlapping of the toes as described is also seen in the X-ray.

Laboratory Findings: A blood count and urinaylsis showed no abnormalities. The Kahn and Hinton tests were negative. Spinal fluid was negative.

Mental Status: According to the Stanford Revision of the Binet-Simon's intelligence test, Clifford showed a mental age of three and two-fifths years. This computed with his chronological age gave him an intelligence quotient of .27. He was classified as a low grade imbecile.

CASE TWO

Willard is a nine-year-old boy who was fifth in order of birth, born at full term (no known birth injuries) and whose birth weight was eight pounds. When he was eight months old, his first teeth erupted. At the age of five he acquired tidy habits and was able to dress and feed himself. The only childhood disease known is measles which he had at nine years. When he was four years old, his peculiarities were first noted; that is, he was large, obese for his age, and was very awkward. He did not talk as an average child and does not talk very much now. His knowledge of English is very limited but he appears to speak and understand French better. The patient has never attended school.

Physical Examination: Willard is a well-developed, obese boy, who is uncoöperative and appears frightened throughout the examination. His facial expression is stupid, dull, but he is more lively than his brother and moves about more quickly. He weighs 120 pounds (54.4 kilos), is 56 inches high (140 cm.), has a chest measurement of 33½ inches (85 cm.), and waist measurement of 35½ inches (91 cm.). The hair is also light brown, complexion is light and the eyes are blue. The head and face are symmetrical and the ears symmetrically formed and placed. There is an external strabismus of the right eye and the palpebral fissure of the right eye is greater than the left. Both pupils are equal and regular and react to light and accommodation. Ophthalmoscopic examination shows optic atrophy and retinal degeneration, but further tests to determine visual acuity are not possible due to lack of coöperation and understanding of the patient. The tongue is of normal size and shape, and protrudes in the median line with no tremors. The teeth are serrated and slightly irregular in arrangement with a few caries. The hard palate is high and examination of the throat shows markedly enlarged tonsils. The thyroid gland is not palpable. Examination of the chest revealed large breasts and no evidence of pathology in the chest. The borders of the heart could not be percussed, the heart sounds are distant, and no murmurs can be made out. The rhythm is regular, and the rate 72. He has a blood pressure of 106/48. Examination of the abdomen shows an obese abdominal wall, a small umbilical hernia which is seen and felt, and no palpable viscera. There is a hypoplasia of the genitalia and the testicles cannot be palpated in the scrotum, though the penis is better developed than that of Clifford who is older. No abnormal reflexes are found. There are six digits on each hand, the supernumerary ones being postaxial in their situations. Supernumerary toes are found on the feet, also postaxial in position (six toes on each foot). The fifth left toe crosses over the fourth and the fifth toe on the right crosses under the fourth. Pes planus and genu valgum are evident. The posture is poor; some lordosis and kyphosis is evident. Hyperextensibility of the elbows is noted. The skin is dry and rough. A large vein is seen coursing superficially over the right breast. The hair is fine, dry and normal in its distribution. Distribution of fat is most pronounced over the shoulders, thighs and abdomen.

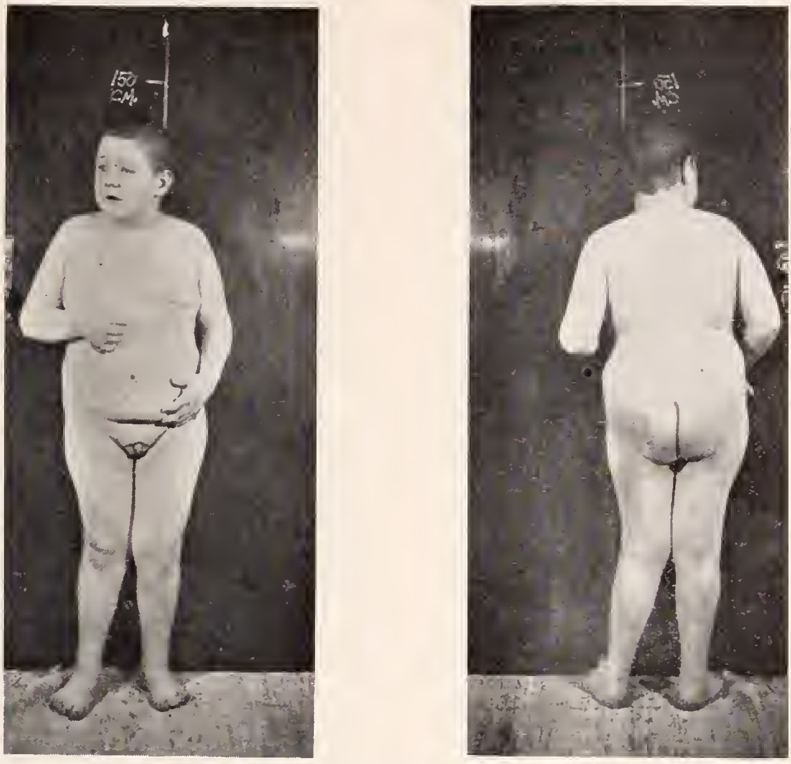

Figure 2, Photographs of Willard.

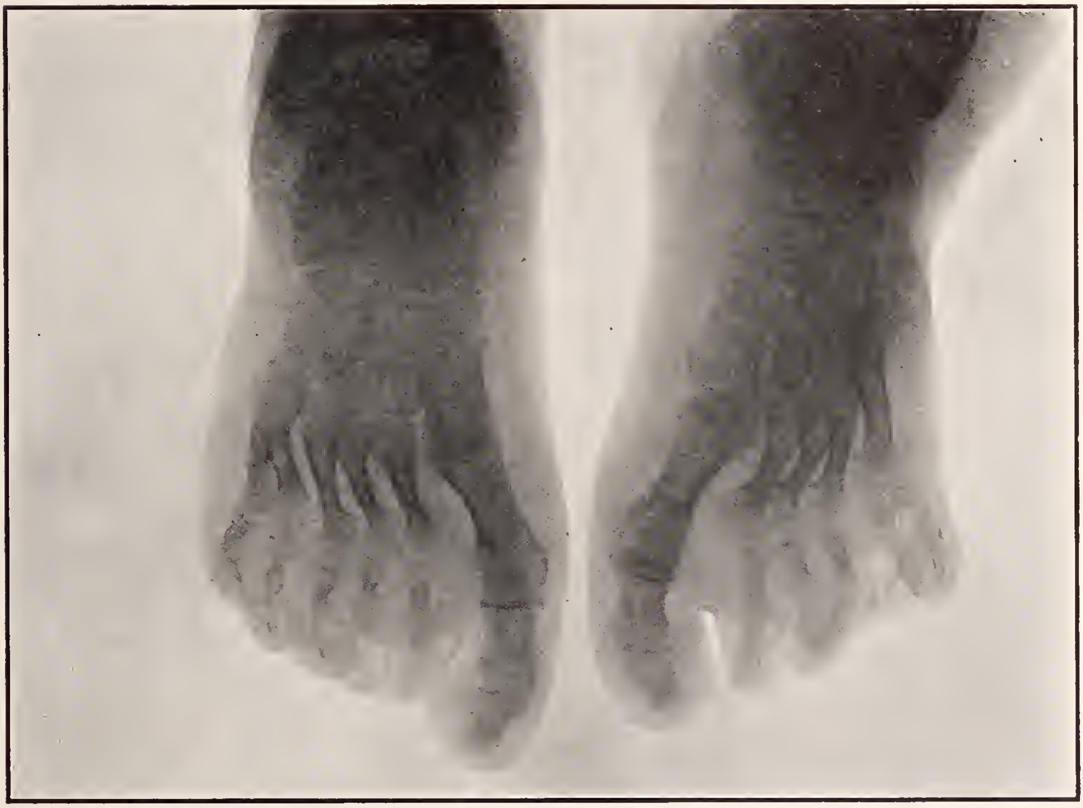

Figure 3, X-ray of Willard's feet.

X-ray Findings: X-ray films show six digits on each hand. The fifth metacarpal on the right hand is enlarged at the base. About midway there is a notch in the bone into which the proximal phalanx of the sixth finger appears to articulate. On the other hand (left), the supernumerary finger which has only two phalanges articulates with a very rudimentary metacarpal only .6 cm. long and which seems to be free in the palm and does not articulate with any other bone.

MEASUREMENTS OF WILLARD'S FINGERS

(Also measured from the films)

	Right	*Left*
1st	4.8 cm.	4.8 cm.
2nd	6.0 cm.	6.3 cm.
3rd	6.8 cm.	7.0 cm.
4th	6.6 cm.	6.6 cm.
5th	5.7 cm.	5.7 cm.
6th	2.5 cm.	2.5 cm.

X-rays of the toes show the same structural origin of the supernumerary digits as in Clifford's. Here the fifth toe on the left overlaps the fourth, while the fifth on the right crosses under the fourth.

Laboratory Findings: A blood count and urinalysis did not show anything unusual. The Kahn and Hinton tests were negative. Spinal fluid was negative.

Mental Status: At the time of examination, Willard is nine years old, according to the Stanford Revision of the Binet-Simon's intelligence test he was found to have a mental age of about one year, which gave him an intelligence quotient of .11. He has been classified as a middle-grade idiot.

DISCUSSION

These two cases show all the cardinal signs consistent with the Laurence-Moon-Biedl Syndrome. There is unquestionable obesity in both patients which is particularly marked in Clifford who weighs 173 pounds (69 kilos) though he is only twelve years of age. The mental deficiency is also definite: Clifford is a low-grade imbecile and Willard is a middle-grade idiot. Familial idiocy with amaurosis is a condition sometimes confused with the Laurence-Moon-Biedl Syndrome. In the former condition the patient is normal mentally until he begins to develop the idiocy. This is not true in such cases as the subjects of this report who were defective mentally from early childhood. Both brothers show retrograde changes in their retinæ.. According to previous descriptions of this syndrome not more than six digits have been reported. ~~Clifford~~, however, shows seven digits on each hand (an additional digit), a condition which has also recently been noted by Levingstone[7] in her case. Polydactylism is symmetrically present in all extremities of the two boys, with the exception of ~~Clifford's~~ left hand where there is a digit nodule instead of a well-formed seventh digit. The genitalia are poorly developed, as one would expect to find. In addition examination of Willard's genitals shows undescended testicles. Other abnormalities are found in both these patients which would place them in the "supercomplete" group of cases. The result of ~~Clifford's~~ physical examination shows that he also has acrocephaly, nystagmus, genu valgum, pes planus; ~~Willard's~~ reveals that he also has strabismus, genu valgum, pes planus, umbilical hernia.

SUMMARY

1. Two cases of Laurence-Moon-Biedl Syndrome have been presented. They show more than the five cardinal symptoms and have therefore been called "supercomplete" cases.

2. One case included in the report is extraordinary because the patient has more than the expected number of digits common to this syndrome.

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Meeting of the New England Otological and Laryngological Society, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts, November 16, 1937

Abstract Editor, Dr. Werner Mueller; Presiding, Dr. Frederick T. Hill

Streptococcus Meningitis. Dr. F. B. Sargent, Providence, R. I.

Four cases of acute suppurative otitis media were reported. One was complicated by meningitis and two showed blood cultures positive for streptococcus hemolyticus. All were treated with sulfanilamide and recovred remarkably well.

Two of the cases which came to mastoidectomy showed that whereas the sulfanilamide brought about prompt improvement in the patients' general condition, it did not inhibit bone destruction.

Oto-Laryngology in the Mid-West, a Comparison of Methods. Dr. E. G. Boss, Springfield, Mass.

During the past several years the author spent a considerable amount of time in some of the large mid-western clinics and thus had ample opportunity to compare the practice of oto-laryngology in that region of the country with that of New England. The following are some of his observations:

By far the greater number of tonsillectomies is performed by the general practitioners. In the James Whitcomb Riley Hospital of Indianapolis peritonsillar abscesses are usually opened under ether anesthesia. It appears that many mid-western oto-laryngologists perform a considerable amount of head and neck surgery which, for the most part, is preempted in New England by the general surgeon. In the author's opinion this state of affairs is due to the influence of Dr. Barnhill. Zinc ionization for the treatment of vasomotor rhinitis has largely been supplanted by the topical application of ½% phenol in olive oil on the middle and inferior turbinates. Ossiculectomy is being almost totally ignored in the mid-west. In the mid-west, to use the author's own words, the oto-laryngologist has won the argument as to whether the Mosher-Toti operation belongs to him or to the ophthalmologist. Several instruments which were invented by mid-western oto-laryngologists were shown.

Two Cases of Anemia Following the Administration of Sulfanilamide. Dr. W. E. Kershner, Bath, Maine.

Two cases of hemolytic streptococcic mastoiditis treated with sulfanilamide were reported. They were of like severity and occurred in otherwise healthy individuals. During the administration of the drug, both cases developed anemia, the R. B. C. dropping to 3,300,000 and 2,900,000 respectively. In both patients the blood picture returned to normal after the drug had been discontinued.

Summary of Lung Abscesses at the Boston City Hospital. Dr. L. M. Freedman, Boston, Mass.

The author made an exhaustive study of all lung abscess cases observed at the Boston City Hospital during the ten-year period from 1926 to 1936. There was a total of 276 proven cases; 200 of these were of medical origin, the remaining 76 occurred as post-operative complication. Of these latter only 16 followed tonsillectomy. In comparing the numbers of the various operations it was found that the ratio of lung-abscess cases to the total number of tonsillectomies was 1:1654, whereas in dental cases it was 1:320, and after gastric operations 1:54. All tonsillectomies were performed in the upright position. Inasmuch as only one lung-abscess occurred in every 1654 tonsillectomies, the author feels that position is of no importance as an etiological factor. The pre-operative condition of the patient is of great importance. The author is convinced that the most potent cause of pulmonary complications is the infection already present in the upper or lower respiratory tract before operation. A rather dramatic case is cited: a patient was not passed for tonsillectomy on account of a lower respiratory infection. He developed a lung-abscess which would have been laid at the door of the tonsillectomy had it been performed.

This paper has since appeared in full in the *New England Journal of Medicine* for April 21, 1938.

Inner Ear Deafness of Unusual Etiology. Dr. P. B. MacCready, New Haven, Conn.

A case of inner ear deafness which occurred following the injection of a prophylactic dose of tetanus antitoxin was reported. The case was unique inasmuch as two other cases which have been reported in the literature so far followed massive doses for the treatment of tetanus.

Use of Tuning Forks. Dr. W. Mueller, Boston, Mass.

A brief demonstration of the various types of tuning forks was given, with special reference to such forks as are usually found in the otologist's office. Inasmuch as the audiometer is not as yet the ideal instrument for audiometry, a plea was made for the proper appreciation and use of the tuning fork. The manner of striking and holding the various forks is important. Forks used for the Rinne test should be "standardized" on a goodly number of subjects with supposedly normal hearing. If the standard for bone and air conduction of such a fork is kept in mind, much can be learned from the Rinne test as regards the type and severity of the patient's deafness, and, incidentally, the Schwabach test is rendered unnecessary.

Atrophic Rhinitis: The Constitutional Factor: and the Treatment with Oestrogenic Hormones. Drs. H. Mortimer, R. P. Wright, and J. B. Collip, Montreal, Canada.

This paper appeared in full in the *Canadian Medical Association Journal*, 37, 445-456, 1937. The following is the authors' own summary:

1. Study of the cranial skiagrams of 68 cases of atrophic rhinitis and ozæna gave evidence in a large majority of a dyspituitary state during or subsequent of the growth period.

2. It is suggested that the disease occurs as a genetically transmitted, more or less localized, focus in a special familial constitution, produced by the mating of dyspituitary individuals, in whom anterior lobe function is unstable in secretory activity; nature or time of activity. It is on this basis that the nasal osseous changes are to be understood.

3. Speculation as to the mode by which a dyspituitary constitution might influence the morphologically specialized conchal mucosa led to the investigation of the naso-genital relationship in the monkey, and recognition of the fact that administration of œstrogenic substances produces a specific response in the conchal mucosa, closely akin to that resulting in other "sex-skin" areas, as already reported.

4. That such specific changes are of an order opposed to the pathological changes occurring in atrophic rhinitis justified the exhibition of dihydroxy-œstrin locally to the nose in this disease.

5. Thirty-one female and seven male patients were available and treated, with results justifying the conclusion that in œstrogenic hormone insufflation there is to be found a therapy for ozæna and trophic rhinitis considerably more effective than any other till now available.

6. Seven patients were found suffering from both atrophic rhinitis and progressive deafness; an eighth case showed both otosclerosis and hypertrophic rhinitis.

Willard H. Bunker, M. D.

The incoming President of our society is well known to most of its members, but a brief review of his record is not out of order. Dr. Bunker was born at Southwest Harbor, Me., Dec. 4, 1886. Three years later his family moved to Red Beach, Me., where his childhood was spent. His early education was received in the local schools. He was graduated from the Bowdoin Medical School in 1909, and interned at the Maine General Hospital.

He has been in active practice in Calais since August, 1910. He became a member of the visiting staff of the Chipman Memorial Hospital, St. Stephen, N. B., in the same year, and was elected President of the staff in 1936. In addition to private practice, he served as Acting Assistant Surgeon in the United States Public Health Service for twelve years, and has been County Medical Examiner for twenty-one years.

He is a member of the New Brunswick and Washington County Medical Societies, and was President of the latter for two terms. He is a Fellow of the American College of Surgeons and the American Medical Association. He has been active in the Maine Medical Association, having served as a member of the Editorial Board of the JOURNAL for three years, and as a member of the Council for two years. He was made President-Elect at the June, 1937, meeting of the Society.

He was married in 1910 to Miss Kate Weeks of Masardis and has three daughters. Madeline, Katherine, and Ruth.

Professionally, Dr. Bunker is recognized as a sound, conscientious, and competent surgeon. Among his friends he is best known as a sea-going sailor. He has been the active Commodore of the Schoodic Yacht Club for the past five years, and is a skipper of his own boat. Widely known, and liked by the profession and the public, he will do credit to the Association. We predict a successful administration.

oring

George L. Pratt, M. D.

If it be true, as stated by Lowell, that " 'tis man's worst fault to let what has been go to waste and in the unmeaning present sink the past," then the Maine Medical Association is to be congratulated upon its election of Doctor George Loring Pratt as its president-elect. Dr. Pratt, be it known, may be said to epitomize in his rugged character what may be referred to as the sterner virtues,—thrift, probity, loyalty, a scrupulous regard for the truth, unswerving adherence to principle, a stubborn unwillingness to compromise with wrong, a few virtues so conspicuous by their absence in some men in high places today.

In whatever activity he has been engaged, whether as captain of the varsity ball team at Bowdoin, or as practitioner of medicine, or as secretary of his county society for twenty-seven years, or as councilor in this association for two years, or as medical examiner for Franklin County for twenty-nine years, or as captain of Medical Corps U. S. A. with the Twenty-sixth Division, A. E. F., his consuming ambition has been to render a service. That he has achieved his aim in his varied pursuits is attested by the success that has attended his efforts and by the confidence and trust which a host of loyal friends repose in him.

He possesses in no small degree the quality of sane leadership so lamentably lacking in the world today. His sound, critical judgment and his power of appraisal prevent him from being deflected from his real purpose by the whims and vagaries that assail us on every hand, and enable him quietly but searchingly and accurately to evaluate things and the motives of men.

As president-elect, and next year as president, Dr. Pratt will exert a definite and powerful influence in our body for constructive and honorable procedure, the hall-mark of a man.

It is to its credit, therefore, that this association recognized merit in a man, who deserved to be called to high office if any man ever did, and insisted upon making its possessor its president-elect.

E. W. G.

The President's Page

To the Members of the Maine Medical Association:

This being my first official opportunity to write the President's Page, I feel rather reluctant in offering my advice to the members of our association or in making any rash promises which I cannot conscientiously fulfill.

The material for the July issue must be in the Portland office on or before June 15th and will be circulated July 8th, therefore I shall refrain from making any mention of our Bar Harbor meeting, other than to express my confidence in the ability of the various committees arranging the program and feel sure it will be a meeting worthy of our association.

I will say, however, that I do anticipate a pleasant year in meeting the members of the County Societies, and it is my ardent desire before the year is ended to have added many of them to my list of friends.

Personally I have no political axe to grind, therefore I expect to be candid in my remarks and courteous to all, and in return I shall appreciate frankness on the part of members of the different committees and will solicit their honest opinion on matters relating to official business.

I feel certain that if we can eliminate prejudice and politics from our association, we can accomplish a great deal and can pass through the year in peace and harmony, which, after all, is an important feature.

During my three years as a member of the Council, and while on the Editorial Board, I have attended many meetings where a lack of coöperation was quite evident. Regretfully, I assume my share of that responsibility, but as I look back I can clearly see the folly of such an attitude. Therefore, I am asking the loyal support of every member of our society, in order that we may carry on successfully and maintain that high standard established by our predecessors.

WILLARD H. BUNKER, M. D.

COUNCIL MAINE MEDICAL ASSOCIATION

Thomas A. Foster,
Chairman
1939

W. W. Bolster
1939

Wm. A. Ellingwood
1941

C. H. Stevens
1941

R. V. N. Bliss
1940

P. L. B. Ebbett
1940

Editorial

The Early Diagnosis of Cervical Carcinoma

Cancer of the uterus is responsible for approximately one-third of the deaths of cancer in women. 90 per cent originate in the portio and the most favorable statistics show, in cases definitely limited to the cervix, about 50% may gain a five-year cure. It is a most unfortunate fact that when cancer of the cervix can be diagnosed quite positively by sight or touch the prognosis is extremely grave. Operative and radiative therapy have seemingly reached a maximum peak, and in some clinics and in the practice of men doing a great deal of gynecology the radical operation for carcinoma of the cervix is rarely resorted to, unless the lesion is extremely limited, since the operation carries with it a high mortality and a risk not commensurate with chances for cure.

Unfortunately there are no specific signs or symptoms of early carcinoma of the cervix. There is, however, one that should arouse the suspicion of the physician and every and all means taken to ascertain the exact cause. It is not present in all cases but occurs with sufficient frequency to require that it not be dismissed as trivial and of no import. Reference is made to spotting and contact bleeding. Carcinomatous epithelium is notoriously brittle, it bleeds with the slightest trauma and often with none at all. As has been emphasized by Schiller the opportune time for the detection of malignancy is in the latent period; that is, the interval between the true onset of carcinoma and the appearance of those signs and symptoms that cause patients to consult a physician. Spotting and contact bleeding must then be considered subjectively significant of that early phase of carcinoma that offers the maximum opportunity for excellent results

By far and large the average woman consults her family physician for advice regarding symptoms resulting from disease in her generative organs and it goes without saying that any aid that will enable one to discover cases at the stage so well described by Schiller must result in a great saving of life and suffering. Schiller's iodine test, based on the fact that cells lacking glycogen stain poorly or not at all, seems to offer much in this important work for given a suspicious finding with this simple method biopsy and examination by a competent pathologist must certainly result in the recognition of the seriousness of the condition if allowed to progress without treatment. Schiller reports 51 cases of *early* cervical carcinoma treated by radical extirpation of the uterus with 49 cures, if cancer can be called cured, but these 49 cases have passed the five-year period which under general acceptance is regarded as fairly positive. However, statistics seemingly show a higher percentage of young women affected with malignancy, which if a fact and the cases can be discovered early enough, it must be obvious that it is to be hoped that radium supplant the more radical hysterectomy if experience shows this to be possible.

Academic discussions as to whether the non-invasive growths, as described and found by the Schiller test, are definite malignancy may interest pathologists but if the profession, as a clinical body, will accept Schiller's belief that metastasis may take place as soon as invasion has begun and that all carcinomas, invasive or not, should receive radical treatment we will see fewer cases in which palliative measures are the only measures left. That these non-invasive lesions can and do become typical death dealing cancers is true beyond rebuttal. The only thing and the right thing is to discover them early, treat them early and radically.

Nominating Committee Report

The Nominating Committee, composed of Drs. C. H. Jameson, Chairman, J. C. Oram, W. E. Webber, E. D. Humphreys, D. F. Bennett and F. B. Ames, made the following report at the Second Meeting of the House of Delegates, June 27, 1938, Bar Harbor, Maine.

STANDING COMMITTEES

Scientific Committees

Stephen A. Cobb, Sanford, Chairman.
Merrill F. S. Green, Lewiston.
H. C. Scribner, Bangor.
Mortimer Warren, Portland.

Committee on Medical Education and Hospitals

Adam Leighton, Portland, Chairman.
Thomas A. Foster, Portland.

Medical Advisory Committee

Carl M. Robinson, Portland, Chairman.
Allan Woodcock, Bangor.
George Young, Skowhegan.
E. V. Call, Lewiston.
C. H. Jameson, Rockland.
Frank H. Jackson, Houlton.
N. A. Fogg, Rockland.
The Secretary, ex-officio.

Legislative Committee

The President, ex-officio, Chairman.
The President-elect, ex-officio.
Charles W. Bell, Farmington.
Adam P. Leighton, Portland.
E. D. Merrill, Dover-Foxcroft.
Thomas A. Foster, Portland.
Anthony E. Peters, Lewiston.
R. V. N. Bliss, Bluehill.
Frank H. Jackson, Houlton.
Henry C. Knowlton, Bangor.
Frederick T. Hill, Waterville.
W. E. Kershner, Bath.
L. H. Smith, Winterport.
W. N. Miner, Calais.

Public Relations Committee.

George R. Campbell, Augusta, Chairman.
Elton Blaisdell, Portland.
Walter Stinehfield, Skowhegan.

Cancer Committee

F. B. Ames, Bangor, Chairman.
E. V. Call, Lewiston.
Magnus Ridlon, Bangor.
E. H. Risley, Waterville.
William Holt, Portland.

Committee on Social Hygiene

E. S. Merrill, Bangor, Chairman.
C. N. Peters, Portland.
C. B. Popplestone, Rockland.

Publicity Committee

E. W. Gehring, Portland, Chairman.
The Secretary, ex-officio.

SPECIAL COMMITTEES

Committee on Nursing Affairs

B. L. Bryant, Bangor, Chairman.
Earl Richardson, Brunswick.
George Tibbetts, Portland.

Tuberculosis Committee

George E. Young, Skowhegan, Chairman.
Loren F. Carter, Presque Isle.
Edward A. Greco, Portland.

Committee on Investigation of Collection Agencies

E. W. Gehring, Portland.

Advisory Committee on Syphilis Control

B. B. Foster, Portland, Chairman.
Carl Blaisdell, Bangor.
Julius Gottlieb, Lewiston.

COMMITTEE ON THE PREVENTION AND AMELIORATION OF DEAFNESS

Harry Butler, Bangor, Chairman.
P. J. Mundie, Calais.
George O. Cummings, Portland.
William Ellingwood, Rockland.
William H. Chaffers, Lewiston.

COMMITTEE ON PROBLEMS OF HEALTH INSURANCE AND STATE MEDICINE

W. E. Kershner, Bath, Chairman.
Frederick T. Hill, Waterville.
Robert W. Belknap, Damariscotta.

COMMITTEE ON GRADUATE EDUCATION

Frederick T. Hill, Waterville, Chairman.
Julius Gottlieb, Lewiston.
N. H. Nickerson, Greenville.
Frank H. Jackson, Houlton.
Eugene Holt, Portland.

COMMITTEE OF REPRESENTATIVES OF APPOINTED HOSPITAL STAFFS

M. C. Moulton, Bangor, Secretary.

COMMITTEE ON MATERNAL WELFARE

Roland B. Moore, Portland, Chairman.
L. S. Mason, Bangor.
R. L. Reynolds, Waterville.
W. W. Bolster, Lewiston.

DELEGATE TO A. M. A.

William A. Ellingwood, Rockland (1939).

* * *

County News and Notes

Androscoggin

The regular meeting of the Androscoggin County Medical Society was held May 19, 1938.

Meeting called to order by the president at 8.40 P. M.

Minutes of the last meeting were approved as read.

The following candidates for membership came up for election: Drs. Gunther H. Rowe, Frederic J. Caron, and Gilbert Clapperton, their applications having been presented at the last regular meeting. Motion made for their acceptance and passed by vote.

On a suggestion by the secretary that the society hold a field day meeting during some convenient day during summer for the members, the response from the members was in its favor. President Sweatt then appointed a committee of the following: Drs. W. P. Webber, R. A. Beliveau, and the secretary to work up a plan to hold it. On motion, and seconded, it was voted that the committee be given power to act on their arrangements.

SCIENTIFIC SESSION

Dr. Roland B. Moore of Portland, assisted by Dr. R. L. Mitchell of Augusta, then presented a very interesting paper in the field of "Obstetrics," a continuation of the program sponsored by the State Health and Welfare Department. This was additionally amplified by movie demonstration.

The meeting was adjourned at 11.10 P. M. until the next regular meeting in September.

Respectfully submitted,

A. E. PETERS, M. D.,
Secretary.

Penobscot

The regular monthly meeting of the Penobscot County Medical Association was held on Tuesday, May 17th, in Bangor.

The following program was presented:

4.30 P. M. Clinic at the Eastern Maine General Hospital. Urinary Incontinence in Children, one case. Unusual Urinary Infections, three cases. Drs. E. S. Merrill and C. E. Blaisdell. Discussion by Dr. Crabtree.

6.30 P. M. Business meeting and dinner at the Bangor House.

Speaker: E. Granville Crabtree, M. D., Chief-Urologist, Beth Israel Hospital, Boston, Massachusetts.

Subject: Some Underlying Principles for the Recognition and Management of Certain Urological Conditions.

FORREST B. AMES, M. D., *Secretary.*

New Members

Androscoggin

Frederic J. Caron, M. D., Lewiston.
Gilbert Clapperton, M. D., Lewiston.
Gunther H. Rowe, M. D., Livermore Falls.

Notices

Bureau of Health Services to Crippled Children Clinic Schedule

Rumford: *Rumford Community Hospital*—1.00 P. M., 3.00 P. M., Wednesday: August 17th, October 12th, November 30th.

OR

Rumford Community Hospital—1.00 P. M., 3.00 P. M., Wednesday: August 17th, October 12th.

Machias: *Washington State Normal School*—1.00 P. M., 3.00 P. M., Tuesday: July 19th, October 4th.

Lewiston: *Central Maine General Hospital*—9.00-11.00 A. M., 1.00-3.00 P. M., Saturday: June 25th, July 30th, August 27th, September 24th, October 22nd, November 19th, December 17th.

Bangor: *Eastern Maine General Hospital*—1.00 P. M., 3.00 P. M., Thursday: July 28th, August 25th, September 22nd, October 20th, November 17th, December 15th.

Portland: *Children's Hospital*—9.00-11.00 A. M., 1.00-3.00 P. M., Monday: June 13th, July 11th, August 8th, September 12th, October 10th, November 14th, December 12th.

Presque Isle: *Northern Maine Sanitorium*—9.00-11.00 A. M., 1.00-3.00 P. M., Thursday: July 21st; Tuesday: August 30th, October 25th, December 6th.

NOTE: Clinic notices will determine which schedule is being followed.

This schedule is subject to change at any time. If changes are made interested workers will be notified.

No Clinic appointments can be made for patients during the last five days prior to the Clinic except for cases who are referred in directly by physicians.

*Tumor Clinics**

Portland: *Maine General Hospital*—Thursday, 11.00 A. M.-12.00 M. Director, *Mortimer Warren, M. D.*

Lewiston: *Central Maine General Hospital*—Tuesday, 11.00 A. M.-12.00 M. Director, *E. V. Call, M. D.*

St. Mary's General Hospital—Wednesday, 4.00 P. M. Director, *R. A. Beliveau, M. D.*

Waterville: *Thayer Hospital* — Thursday, 9.00-11.00 A. M. Director, *Edward H. Risley, M. D.*

Sisters' Hospital — Thursday, 9.00-11.00 A. M. Director, *Blynn O. Goodrich, M. D.*

Bangor: *Eastern Maine General Hospital*—Thursday, 11.00 A. M.-12.00 M. Director, *Magnus F. Ridlon, M. D.*

* Approved by Maine Medical Association.

State of Maine Board of Registration of Medicine

Physicians licensed to practice medicine in Maine at the November, 1937, session:

Cyril E. Bousfield, M. D., Northeast Harbor, Maine.

Paul L. Brooks, M. D., Portland, Maine.

Frederick Caron, M. D., Lewiston, Maine.

William F. Corbett, M. D., Amesbury, Massachusetts.

John B. Curtis, M. D., Danforth, Maine.

Kenneth E. Dore, M. D., Auburn, Maine.

John Robert Feeley, M. D., Orono, Maine.

Charles F. Larrabee, M. D., Washburn, Maine.

William E. MacDonald, M. D., Boston, Massachusetts.

William F. Mahaney, M. D., Biddeford, Maine.

Joseph E. Porter, M. D., Boston, Massachusetts.

Joseph Raffa, M. D., Hartford, Connecticut.

James Vincent Scola, M. D., Springfield, Massachusetts.

Edwin E. Smith, M. D., Wollaston, Massachusetts..

Mary E. Wilbur, M. D., Lewiston, Maine.

Vernon Phillips Williams, M. D., Boston, Massachusetts.

Allan Craig, M. D., Bangor, Maine.

THROUGH RECIPROCITY

Austin J. Brogan, M. D., Quoddy, Maine.
George E. Dash, M. D., Cincinnati, Ohio.
Donald E. Dement, M. D., Bangor, Maine.
Havilah E. Hinman, M. D., Orono, Maine.
Wilson Harry McWethy, M. D., Bronxville, New York.

Physicians licensed to practice medicine in Maine at the March, 1938, session:

Leon Babalian, M. D., Falmouth Foreside, Maine.
Jean Bousquet, M. D., Lewiston, Maine.
George W. R. Bowie, M. D., Rangeley, Maine.
James R. Cogan, M. D., Worcester, Massachusetts.
Joelle C. Hiebert, M. D., Lewiston, Maine.
Rocco G. Lapenta, M. D., Hartford, Connecticut.
Burton S. Marsh, M. D., Bangor, Maine.
Joseph Memmelaar, M. D., Bangor, Maine.
Paul A. Millington, M. D., West Townsend, Massachusetts.
James E. Poulin, M. D., Baltimore, Maryland.
Alfred W. Powers, M. D., Edmundston, N. B.
Arthur C. Pratt, M. D., Danielson, Connecticut.
Sydney Sewall, M. D., Hartford, Connecticut.
Eugene H. Sterne, Jr., M. D., Boston, Massachusetts.
W. Franklin Wood, M. D., Waverly, Massachusetts.
Richard T. Munce, M. D., Fall River, Massachusetts.
Charles N. Denison, Dayville-Killingly, Connecticut.

Special examination, April 16, 1938:

Franklin F. Ferguson, M. D., Portland, Maine.

Adam P. Leighton, M. D., *Secretary.*

"The Doctor" Now in a Permanent Home

Sculpticolor of Fildes' Masterpiece Goes to Rosenwald Museum

The $150,000. reproduction of the Sir Luke Fildes masterpiece, "The Doctor," first shown by the Petrolagar Laboratories at Chicago's Century of Progress Exposition in 1933, was recently presented by its owners to the new Rosenwald Museum of Science and Industry in that city.

Following the two World's Fairs, "The Doctor" Exhibit went on a tour of 50,000 miles and was viewed by over five million people in eighteen principal cities throughout the country.

Designed to remind the public of the importance of the family physician, it required the full time of the late Chicago sculptor, John Paulding, and the noted artist, Rudolph Ingerle, and a large corps of assistants, and took nearly a year to complete.

In its new location in the Rosenwald Museum it will be seen by millions of visitors annually.

Book Reviews

"Common Neuroses of Children and Adults"

By O. Spurgeon English, M. D., Clinical Professor of Psychiatry, Temple University Medical School, and Gerald H. J. Pearson, B. A., M. D., Assistant Professor of Pediatrics, Temple University Medical School. Published by W. W. Norton & Co., Inc., New York, 1937. Price, $3.50.

The authors of this book feel that there exists a need for it among medical students and practitioners. They attempted to bring together into a comparatively small (320 pages) volume a large amount of material dealing with the common neuroses of children and adults according to the psychoanalytic concepts, especially of Sigmund Freud and some of his pupils.

The book is divided into three parts. Part One deals with psychophysiology and psychopathology of the neuroses. In Part Two the common neuroses of childhood are discussed in nine chapters. Part Three presents the common neuroses of adults; seven chapters are devoted to this field.

Throughout the entire work the authors have tried to elaborate upon the notion that infantile neuroses are directly or indirectly the result of a great variety of traumata of childhood and that the neuroses of the adult can be explained by treating them as if they were repetitions of infantile behavior in childhood conflict-situations carried over into adult behavior levels. The various critical situations which confront almost every human life, such as puberty, termination of school life, the various phases of the love life with its many pleasure and pain producing features, marriage and the establishment of a home and a family which may be accomplished satisfactorily or unsatisfactorily or not at all, variation in the vocational and financial life, loss of loved or needed persons through death, separation, etc., etc., demand more or less definite, socially prescribed behavior readjustments. If such adjustment cannot be successfully carried through by the individual and a neurosis results, the psychoanalytically informed physician can help such a one with patient coöperation in a therapeutic effort to retrace the course of his or her life and accumulate such helpful information about these various crises which show how certain experiences finally condensed into strains and stresses which precipitated the final break. Usually a good deal of analytical work is required before appropriate therapeutic efforts can be instituted with any hope for a reasonable degree of success. The authors show the way in which the psychoanalytical methods of therapy aim to achieve such success.

"A Biological Approach to the Problem of Abnormal Behavior"

By Milton Harrington, M. D., Psychiatrist, Institution for Male Defective Delinquents, Napanoch, N. Y. Formerly Consultant in Mental Hygiene, Dartmouth College. Published by the Science Press Printing Company, Lancaster, Pa., 1938.

The author of this book, which apparently must be considered as volume one of a two-volume set, believes that he has accumulated sufficient scientific material to prove that both the motivistic or psychologic as well as the mechanistic or anatomic theories of human abnormal behavior are faulty and sets out to promote his own, the biomechanistic, theory. He claims that his method of approach proceeds from the normal to the abnormal in contradistinction to the psychoanalytic schools which proceed from the abnormal or morbid state in their case studies. He believes that he has discovered three fundamental differences between his and the psychoanalytic method: the method of approach from the normal to the abnormal; the basic concept that every phenomenon occurs as the result of an action or change of some sort; and, that the factual material to be used in the construction of this theory is based upon the fundamental facts of anatomy, physiology, medicine and general biology, together with the facts of normal and abnormal psychology.

The ultimate success of the author's work cannot be fully appreciated until after his second work, dealing with psycho-orthology, can be studied, which is to complete the trilogy: psychophysiology, psychopathology, and psycho-orthology of the biomechanistic approach to the Problem of Abnormal Behavior.

"Symptoms of Visceral Disease"

A STUDY OF THE VEGETATIVE NERVOUS SYSTEM IN ITS RELATIONSHIP TO CLINICAL MEDICINE

By Francis Marion Pottenger, A. M., M. D., LL. D., F. A. C. P. Medical Director, Pottenger Sanatorium and Clinic for Diseases of the Chest, Monrovia, California; Professor of Clinical Medicine, University of Southern California; Author of "Clinical Tuberculosis," "Tuberculin in Diagnosis and Treatment," "Muscle Spasm and Degeneration," etc. Fifth Edition. Published by The C. V. Mosby Co., St. Louis, 1938. Price, $5.00.

This excellent textbook, which began its circulation among the medical practitioners in 1919, now presents itself again in a greatly revised and more complete new edition. Visceral pain is now dealt with in a separate chapter. A new chapter describing the vegetative centers in the brain and cord has been added. Nearly every chapter has been partially or wholly rewritten.

The author wishes to have us all understand that there is, in every patient that comes to us for medical help, a human being suffering from some kind of disease process as well as there is a disease process which is disturbing the feeling of well-being of a human being. After man is born with a make-up and capacities all his own, "the chief factor in adjustment to man's environment is the afferent or ingoing impulse of the reflex." "Man is a receptor mechanism, influenced by every force in his environment."

The book is divided into Introductory chapter and three parts. Part One deals with the vegetative nervous system; Part Two with the relationship between the vegetative nervous system and the symptoms of visceral disease; and Part Three with the innervation of important viscera with a clinical study of the more important viscerogenic reflexes. There are eighty-seven illustrations and ten color plates to illustrate this very instructive text.

"Essentials of Obstetrical and Gynecological Pathology"

WITH CLINICAL CORRELATION

By Marion Douglass, M. D., F. A. C. S., Assistant Professor of Gynecology, Western Reserve University, and Robert L. Faulkner, M. D., Senior Clinical Instructor in Gynecology, Western Reserve University. Published by The C. V. Mosby Co., St. Louis, 1938. Price, $4.75.

In presenting this thin volume to the medical reader, the authors put before the profession the results of their many years of experience in teaching the essentials of pathology at the Western Reserve University and associated institutions. The plan of the work is to picture and discuss briefly from a clinical point of view the normal histological and then the common or more important pathological characteristics of the structures of the organs of regeneration. The textual material is appropriately explained with the help of one hundred and forty-eight excellent illustrations. In both pictures and text the authors closely followed the elementary material as it is presented each year to their students. They feel that in this form of presenting the subject of obstetric and gynecologic pathology, the normal or usual course in pathology is greatly enriched.

"The Heart in Pregnancy"

By Julius Jensen, Ph. D. (In Medicine), University of Minnesota, M. R. C. S. (England), L. R. C. P. (London). Assistant Professor of Clinical Medicine, Washington University School of Medicine; Assistant Physician to Barnes Hospital; Physician to St. Louis Maternity Hospital and St. Louis City Hospital. Published by The C. V. Mosby Co., St. Louis, 1938. Price: $5.50.

The author of this work has spent more than four years in the collection and compilation of literature dealing with the functional variations of the heart during pregnancy. It was found that all available methods which have been devised for the purpose of determining the competence of the heart ought to be employed. The heart must be, and here is, considered, together with the circulation, on a dynamically functioning anatomical basis.

The book is divided into three parts. Part One presents material relating to the effect of pregnancy and the normal heart. The increase in cardiac work during pregnancy is brought before the reader in ten chapters. The mechanisms

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whereby the heart meets the increased demands of pregnancy are pointed out in seven chapters. Another eleven chapters are devoted to material dealing with the effects of pregnancy upon the normal heart. In Part Two the abnormal cardiac impulse formation during childbearing are put forth. Part Three, comprising nineteen chapters, thoroughly goes into the problems of organic heart disease and pregnancy. The various features are presented in two large groups; namely, the rheumatic heart disease group and the group of the nonrheumatic heart diseases. There is a bibliography of more than twenty pages.

The author found what most obstetricians find in practice: namely, that there are women with apparently normal hearts which may develop signs and symptoms of cardiac distress during pregnancy, which distress may demand various forms of treatment. He found, also, however, that there exists a large amount of worthwhile literature scattered widely and of contradictory nature concerning methods of approach and treatment. The book under review constitutes a sincere and serious attempt to bring together what is known and considered worthwhile information and to bring more clarity into the problems of cardiac function in pregnancy.

"Hemorrhoids"

By Marion C. Pruitt, M. D., L. R. C. P., S. (Ed.), F. R. C. S. (Ed.), F. A. C. S., Atlanta, Georgia. President, American Proctologic Society; Associate in Surgery, Emory University School of Medicine; Proctologist, Grady Hospital, Crawford W. Long Memorial Hospital, Georgia Baptist Hospital, and Atlanta Antituberculosis Association; Formerly Resident Surgeon, Westminster Hospital, London, England; Lieutenant, Temporary and Honorary Commission, R. A. M. C., Major, U. S. M. C. Published by The C. V. Mosby Company, St. Louis, 1938. Price: $4.00.

This remarkable monograph of one hundred and seventy pages and seventy-three very excellent illustrations, several of which are multicolored highly artistic works of art, offers the problems of hemorrhoids and their solutions to the medical profession in a most attractive manner. Among the several methods of treatment recommended, the most universally employed ones seem to be those of ligature and excision. All techniques, including the author's, are fully described and clearly illustrated. In the author's opinion both the injection treatment and the operative treatment promise curative results for hemorrhoids in 80 to 90 per cent for the former and 92 to 96 per cent in the latter, in the hands of experienced operators.

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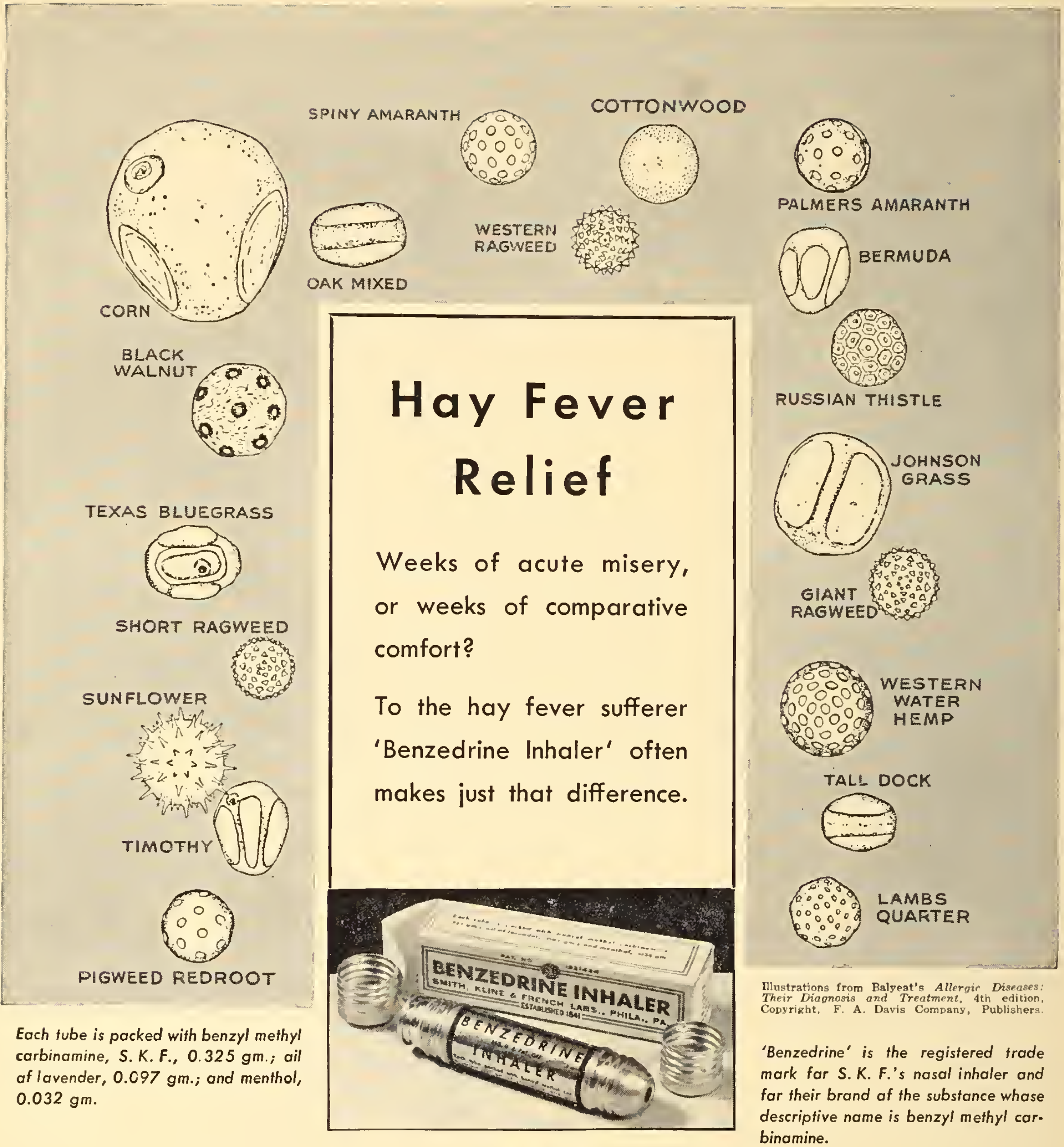

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BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

VI. COOLING THE TIN CONTAINER AFTER THERMAL PROCESSING

● On this page we have previously described certain basic operations in commercial canning procedures. These have included cleansing of the raw material; blanching; exhausting or pre-heating; sealing the tin container; and thermal processing of the sealed container. In this—the last of this series—we shall discuss the final basic operation, namely, the cooling of the sealed can immediately after the heat process.

One main reason for rapid and thorough cooling of the can contents—as soon as the objective of the heat treatment has been fulfilled—is more or less self-evident. Prompt cooling checks the action of the heat and thus prevents undue softening in texture or change in color of the food. Also important, particularly in the case of foods of an acid nature, is the prevention of excessive chemical action between the food and the metal container, which may occur if the contents of the can remain hot for an extended period of time. In modern practice, two types of cooling are commonly used, namely, air cooling and water cooling.

Air cooling, as the name implies, involves cooling of the tin container by facilitating radiation of its heat into the air. This type of cooling is adaptable to certain products in small cans. In other products, or in the case of larger cans, it is employed chiefly when the slower loss of heat, characteristic of this cooling method, is essential either for preservation of the food, or for the production of certain quality characteristics in the final product. Modern air cooling is accomplished in well ventilated, specially designed warehouses where the cans are piled in rows, allowing ample space between rows for efficient air circulation.

The several methods of water cooling and the technique by which they are carried out are detailed elsewhere (1). Briefly, water cooling may be effected in a variety of ways. The hot cans may be cooled by admitting water into the retort in which they were processed, or they may be cooled after removal from the retort by conveying the cans through tanks of cold, running water or through cold water showers. Large size, or irregularly shaped cans—processed under steam pressure—must be cooled in the closed retort at the end of the process to avoid undue strain on the containers. This is accomplished by "pressure cooling" in which pressure is maintained in the retort during the cooling of the cans, to counterbalance the pressure which develops during the process within the can itself. Commercially, cans are water-cooled to about 100°F. so that enough residual heat remains to dry the can exterior.

Present day canners are fully aware of the importance of cooling their products rapidly and completely as soon as the process is completed, in order to insure the production of canned foods with high quality characteristics. Consequently, in modern canneries the cooling operations are strictly supervised like the other basic operations in the commercial canning procedure. After inspection and labeling, the cooled cans are then ready to enter distribution channels for delivery to the consumer.

In this series of six discussions, we have attempted not only to describe the basic steps in commercial canning procedures, but also to explain their purposes. We trust this series may help bring a better understanding of this important method of food preservation.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

(1) 1936. A Complete Course in Canning, 6th Ed. The Canning Trade, Baltimore.

This is the thirty-ninth in a series of monthly articles, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research. We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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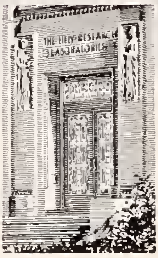

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The Official Organ of

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*Low Transverse Cervical Cesarean Section**

Adam P. Leighton, M. D., Portland, Maine

Cesarean Section has occupied a prominent place in obstetrical literature for the past decade, and probably no surgical operation has a more ancient and fascinating history. Its growth and development has extended over many hundreds of years, and while this maturing process has left in its wake a disastrous trail of maternal mortality, from it has emerged a technique which has been life saving to both mother and child.

The history surrounding Cesarean Section and the indications for its performance are too well known to each and every one of you to allow for tiresome repetition. For twenty years and more I had made use of the so-called Classical Cesarean as occasion demanded, and it was only through an opportunity to witness, some five years ago, two such Cesareans, as I describe today, performed by Dr. Louis E. Phaneuf of Boston at the Carney Hospital that I became acquainted with Low Cervical Cesarean. Worried too often by the aftercare and stormy convalescence of the patients upon whom I performed the Classical operation, and having been dissatisfied with some of the results, which on several occasions were unfortunate, to say the least, I turned to this newer technic with avidity. I only wish that I might have learned earlier of the efficacy of this operation, for since 1933 it has been a joy indeed to witness an infinitely better post operative picture. I, too, am indebted to Dr. Phaneuf for the loan of the stereopticon slides which I am presently using in illustration of this operation's technique, which, for the past five years, I have substituted for the Classical Cesarean Section.

In my own private practice I have attended 2,472 women in childbirth, the last one having been a Cesarean performed last Saturday morning. My records have been carefully kept these past twenty-five years, and I note that I have performed Cesarean Section 181 times or in 7% of the entire number of births. This percentage may seem rather high, and yet, when one studies the available statistics, I guess it comes within the limits of possible conservatism. My cases have all been private patients and over 20% of these Cesareans have been referred to me or to my hospital, where they entered with a clear-cut indication for abdominal hysterotomy or certain findings which obviously demanded such treatment. With the exception of two women in this number, not one of them has been a case of attempted delivery or otherwise "tampered with" before I saw them.

My mortality rate has been possibly lower than the general run of so-called "hospital" cases for that reason. Forty-seven of these 181 Cesareans have been of the Low Transverse cervical type. My maternal mortality was 5.2%, there having been seven deaths, all of which occurred following the classical operation. Of these 47 Low Cervicals, all the mothers and babies are alive today.

These Cesareans were indicated and performed for the following obstetrical abnormalities:

Placenta Prævia, 3; Previous Cesarean Section, 16; Primary Uterine Inertia, 1; Ablatio Placentæ (Internal and External Accidental Hemorrhage), 2; Pelvic Tumor (Fibroid of the Uterus), 1; Pre-Eclamptic Symptoms, toxemia where treatment availed nothing and symptoms persisted or increased, 11; Eclampsia, 6; Medical Complications, Heart Disease 4, Pulmonary Tuberculosis 1, Post Mortem, 1; and for Dystocia due to pelvic deformity and disproportion between passage and passenger or abnormal position, 134.

There were five deaths attributed to ileus, one to peritonitis and one to pulmonary embolism.

The post-mortem Cesarean is not counted in this number as the patient was received in a moribund condition, dying as she arrived at the door of my hospital. Cesarean Section was done five minutes later and the girl baby is now 17 years old and living in Biddeford, Maine.

I frankly believe that the ileus following Cesarean Section is due in great part, if not usually, to the delivery of the uterus through the abdominal incision to allow for placental extraction and its subsequent replacement in the abdomen. The irritation and immediate displacement of the bowels plus the large amount of "spill" which directly enters the abdominal cavity and the abnormal pressure of the uterus in its relocation would seem to me to be a sensible and plausible explanation of the etiological factors in this mechanical obstruction of the bowels. With the low transverse cervical section, the uterus remains in its accustomed position and bed during the entire operation, simulating the second and third stage of normal delivery.

The anæsthesia used in all cases was gas-oxygen and ether, with the exception of the case of active tuberculosis of the lungs and one pre-eclamptic, where spinal anæsthesia was used with excellent results.

Mine is the experience of many obstetricians. I have done Cesarean Section when I conscientiously thought it indicated and afterwards have wished that I had been more conservative, and, too, I have in mind many cases where I wished that I had the opportunity to decide again, for Cesarean Section would have been the proper choice. It has been a nicety of judgment with me oftentimes to decide the question, and where I did once upon a time waver when confronted with the necessity of decision, I truthfully state that today I have no fears of the unfortunate sequelæ of old when we routinely employed the Classical operation in a given case.

Anatomically, the lower uterine segment may be approached by any one of three methods in performing Cesarean Section:

(1) Extraperitoneally, the operation most used nowadays being the modification of Latzko.

(2) Transperitoneally, "peritoneal exclusion," represented by the procedure of Veit-Fromme-Hirst, where the layers of parietal and visceral peritoneum are united by sutures, thus creating a so-called extraperitoneal space.

(3) Intraperitoneally, where the abdomen is opened by a longitudinal median suprapubic incision and the bladder separated from the lower uterine segment which is incised longitudinally or transversely to accomplish delivery. Following the closure of the incision, the bladder is sutured back on the uterus in such a way that the incision becomes retrovesical, retroperitoneal or subperitoneal. The cervical incision thus becomes isolated from the general peritoneal cavity.

The Extraperitoneal operation is usually performed on the frankly infected woman whose labor has been mismanaged. My personal feeling in this regard is that when a parturient patient has reached this stage of neglect and needs an abdominal delivery, her life is better protected by the supravaginal amputation of the uterus or the so-called Porro Cesarean Section. It is an established fact that a virulent organism, the streptococcus for instance, may find its way through the intact peritoneum after the extraperitoneal Cesarean and cause general peritonitis. These severely infected patients, as a rule, form but a small group in the large series of cases. The Transperitoneal operation—peritoneal exclusion—is reserved for women who have been long in labor, whose membranes have been ruptured for many hours and who have been subjected to vaginal examinations. Although no clinical signs of infection may be present in the light of our present knowledge, they are considered as undoubtedly infected. The Intraperitoneal operation, which I prefer to perform, with a transverse curved incision in the lower segment, is used on the average patient upon election, and may be even safely executed after an adequate test of labor under aseptic conditions.

Abdominal delivery through the lower uterine segment was proposed by Frank, of Cologne, in 1907, because of his dissatisfaction with the results of the Classical Cesarean Section, especially in women who had been long in labor and were infected or presumably infected. While this method soon found adherents in Germany, it received but little consideration elsewhere. In the United States, this procedure was seldom mentioned until 1915. Since then it has become firmly established as a standard procedure and has replaced, or is gradually replacing, the Classical or corporeal Cesarean Section in many important obstetrical clinics.

When Cesarean Section is performed under favorable circumstances and in proper surgical hands, it is amongst the easiest and safest of abdominal operations. On the other hand when performed after a woman has exhausted herself with efforts to bring about an impossible delivery or attempts have been made to deliver per vaginam, it becomes very dangerous. It is of course most important, therefore, to recognize the indications for Cesarean Section, as early as possible, and to decide finally upon its advisability. Even with the utmost of care and consideration and examination, with proper study of pelvimetry in a certain case, we are unhappily awakened to the fact that we should have resorted to Cesarean instead of allowing for labor. I well remember such a case. She was a doctor's wife, one to whom I had given proper prenatal care and thought, and she was assured of mechanical normalcy. It became a most difficult forceps delivery, a posterior position with extreme dystocia. A brother physician, who was the lady's husband, was present, and a dead child was the result. I would willingly pay a thousand dollars to have the case to do over, for Cesarean was obviously called for, yet there was not one thing which would lead me to expect such an unfortunate happening with planned normal labor. No wonder that many lean too often towards Cesarean when such cases present themslves, yet without clear-cut indications for delivery by the abdominal route. We all have such poor luck, I guess, sooner or later, and few there are whose judgment is infallible. Since this occurrence I have resorted to Cesarean more often than earlier in my practice, I confess, and especially since I gave up the classical route for the low cervical Cesarean.

One important factor in favor of the low operation is that intestinal adhesions and obstruction are found rarely following this method of delivery, while adhesions of the intestines to the uterine scar, after the Sanger operation, are not uncommon. It has been proved that the scar of the low or cervical operation is much stronger than that placed in the uterine body.

I was rather amused at the remarks of two of my good friends, both excellent surgeons, that they were interested in the low cervical operation but the separation of the bladder previous to the incision in the lower segment, deterred them. The turning back of the bladder flap is the easiest part of the operation, and if one is but certain to pick up the peritoneum above the bladder reflection and cut it evenly along its border, it may be easily separated, and there is no danger of trauma.

The scar of the incision in the lower segment is never seen at subsequent operations. There are no adhesions. I have yet to have any patient complain of any bladder symptoms, such as pain, burning or frequent micturition after this Section.

The scar following low cervical Cesarean as aforestated is much stronger, and theoretically, at least, it would be assumed that birth might safely be allowed per viam naturalis following pregnancies. I have delivered three women normally upon whom I had previously done the Classical operation for relative indications. Two of them came along in labor so quickly that I had no other recourse, but in one case where I allowed the woman to make the choice of normal labor and delivery, it was such a long tedious affair, it kept me on the "anxious seat" indeed. The danger of uterine rupture is truly real and omnipresent and I find it difficult to be complacent and to allow for this procedure. The dictum, "Once a Cesarean, always a Cesarean," is to my mind correct and I do not allow any woman to try to deliver herself where there has been any kind of a previous Cesarean Section. The risk is too great under any conditions, I believe.

I have become assured of the superiority of this operation and the worries coincident and subsequent to the performance of the classical Cesarean have all disappeared. I am sorry that I did not avail myself of the opportunity to make use of the Kroenig low cervical operation at an earlier date, thereby preventing the necessity for sleepless nights and the difficult explanation to relatives when things went wrongly with the old-time hysterotomy. In all these cases of low cervical Cesarean, the one joyous thing connected with it, is the fact that it obviates the necessity of oftentimes coming into the patient's room a couple of days after the operation and looking into the face of a hot, flushed, anxious, sweaty, puking woman with an enormously distended abdomen, for in distinct contrast to the usual sequel to the old Sanger operation, one sees a flat-bellied, normal, contented, comfortable surgical patient!

The Technique of the Low Transverse Cervical Cesarean Section:

Step 1. The patient is catheterized, anæsthetized and placed in the partial Trendelenburg position. 1 c.c. of Gynergen is injected intramuscularly. The abdomen is opened by a median incision about six inches long, starting at the symphysis and ending near the umbilicus. The peritoneal cavity is entered between the bellies of the recti muscles. A Doyen retractoris introduced at the lower angle of the incision and the lower uterine segment is well walled off with a packing off piece. 1 c.c. of pituitrin is now injected.

Step 2. Cervical incision and delivery: The uterine peritoneum, where it is loosely attached above the bladder insertion, is incised transversely, keeping slightly above the edge of the bladder on both sides and the bladder is separated from the anterior surface of the lower segment of the uterus. I like to place the Doyen retractor UNDER the bladder after separation as it allows for better retraction and inspection of the cervical surface. The assistant makes traction upward on the uterus to bring the lower segment nearer the surface. A small transverse nick is made in the median line, as low as possible in the cervix: this is extended laterally with bandage scissors, curving the incision upward, to give more room and to avoid the uterine vessels. The child is delivered by raising the head on the palm of the hand coincidently with firm pressure being made downwards on the fundus. If the breech presents, the infant is naturally extracted by the feet. The placenta and membranes are expressed through the incision. If the cervix is fully dilated, some operators drop the cord into the uterus and allow the placenta to be expressed through the vagina after closure of the cervical incision and the suturing of the peritoneal flap to the uterus. Personally I have never done this and I can visualize possible trouble that might ensue, were the placental tissues or secundines to be accidentally caught by the suturing process. Too, I feel that to Credè the uterus and use expulsive force to deliver the placenta, might do irreparable harm to the line of sutures. I extract and deliver the placenta in each case immediately after birth of the child and feel that it is better technique. The "spill" from the retroplacental bleeding is easily taken care of and the amount that finds its way into the abdominal cavity is negligible.

There is very little hemorrhage from the transverse incision in the lower segment, as a rule.

Step 3. Closure of cervical incision and suture of the peritoneal flap. The cervical incision is closed in two layers, the first with interrupted and the second with a continuous suture, No. 2 chromic catgut being used, the first layer takes in part of the muscle; the second layer takes in the remainder of the myometrium and the fascia of the lower uterine segment completely covering the first. The peritoneal edge at the bladder reflection is now sutured to the uterus above the cervical incision, in the middle line, with a No. 0 chromic or No. 2 plain catgut. I like to make use of a kind of continuous mattress suture for I find that firm and smooth union of the peritoneal surfaces always follows over the transverse cervical incision if covered well, making it entirely retrovesical.

Step 4: Closure of the abdominal wall is made in the usual way.

The aftercare is that of any abdominal operation. I allow no laxative to be given until the end of the third day. Enemata if really needed may be used. 1,500 c.c. of saline with 10% dextrose, intravenously is administered for the first two or three days. Each patient is allowed and encouraged to sit up in the semi-Fowler position after the third day for I believe that this favors involution and by increasing vaginal drainage, the chances for any sapremic process is lessened.

To me this operation is ideal. To those of you who heretofore have clung to the classical Cesarean, I recommend its trial and adoption. It's just as easy to accomplish, it's results are routinely excellent and your moments of anxiety and worry most certainly will be ended.

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*Mortality in Surgical Diabetes in the General Hospital**†

A MEDICAL STUDY OF 100 OPERATED CASES

By E. R. Blaisdell, M. D., F. A. C. P., Portland, Maine

Publications from general hospitals dealing with statistical reports of the mortality rate in surgical diabetes are scanty. The failure of the general hospital to report the results of treatment in this group of patients may be due to it's relatively high death rate as compared to that of the special clinic. However, in a comparative study, a few factors should be considered. In the general hospital, it is a common custom for the patient to be treated by rotating medical and surgical services and here the responsibility is frequently divided among six or more men, each of whom may have a slightly different opinion as to the manner in which the treatment should be carried out. Of still greater importance, it would seem to the writer, is the condition of the patient at the time of his arrival at the hospital. Service patients, and they represent more than fifty percent of the surgical diabetics treated in the general hospital, have frequently been ill for several days before admission and, in case of a lower extremity infection, it is extremely rare to see a patient on admission whose temperature is not at least between 100° and 101°. Many of them live in the country, several miles from a physician, and do not call for medical aid until the extremity is infected. It is not uncommon for the patient to keep a sore extremity concealed until the odor of decaying flesh or the sudden loss of appetite from toxemia reveals the secret. It is surprising to see the extensive sloughing that can take place in a diabetic extremity without complaint of pain. Those with long standing untreated diabetes have a marked decrease in sensitivity of the lower extremity and, for this reason, an individual whose vision is frequently affected by lens changes may have one or two gangrenous toes without his knowledge. The writer does not mean to infer that gangrene does not occur in private patients but such patients as a whole do arrive at the hospital in better condition—probably due to the fact that their home conditions are better and the physician is consulted earlier. Therefore, hospitals maintaining relatively large ward services may show higher mortality rates in surgical diabetes than those institutions in which the ratio of private patients to service patients is greater; this may be especially noticeable in operations dealing with acute abdominal emergencies and lesions involving the lower extremities.

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† From the Medical Service, Maine General Hospital.

* Read at the monthly staff meeting, January 14, 1938.

Among the few general hospital reports on surgical diabetes was an instructive article by Williams and O'Kane[1], whose studies extended over a period of five years, from 1931 to 1935 inclusive, during which time 218 operated cases were treated. In the earlier part of this period, when the surgery was done by rotating surgeons and the medical care was given by requested consultations, the mortality rate was 50%—whereas, during the last year, when one surgeon did all of the amputations and one internist took care of the medical treatment, the rate fell to 20%. They stressed the importance of close coöperation between the surgeon and internist in the handling of these patients.

The following series of 100 surgical diabetics was obtained by asking the record room clerk at the Maine General Hospital to go back over the diabetics treated by the writer, both as service and private patients, until 100 operated cases were found. None were discarded unless the diabetes was not severe enough to require insulin, and no attempt was made to separate private from service patients. The surgery was done by members of the surgical staff and, in most instances, the surgeon who performed the operation followed his own case during the entire period of hospitalization. The average age of all patients was 59 years and the average amount of insulin per individual was 39 units daily. Among the 100 patients, there were 41 amputations of the lower extremity, 26 abdominal sections for abdominal and pelvic surgery, 13 carbuncles excised, 5 prostatectomies, 5 fractures, 4 mastoidectomies, 3 cataract operations, 2 hernias and 1 double mastectomy.

In this series of 100 surgical diabetics, there were 16 deaths. The highest mortality occurred in those with lesions of the lower extremity, with 10 deaths in 41 amputations. All of the 10 fatal cases had, on admission, infected sloughing gangrene and a temperature above 100°; 6 of this number were recorded as dying from septicemia and 4 from surgical shock; 2 of the latter had a blood transfusion immediately following the operation. All were free from acidosis and were not dehydrated at the time of operation. Abdominal and pelvic surgery accounted for 4 deaths in 26 patients. A man, aged 79, with a ruptured appendix and peritonitis on admission, died of sepsis. The second death resulted from pulmonary embolism following cholecystectomy. Another patient died of bronchopneumonia following a hysterectomy and excision of a recto-vaginal fistular. The fourth death was caused by postoperative hemorrhage following cholecystenterostomy for cancer of the pancreas. There was 1 death from postoperative hemorrhage following a second stage prostatectomy. Excision of a large carbuncle accounted for another fatality in a man who was extremely toxic on admission.

The general routine of treatment was as follows: Unless an acute emergency existed, the patient was treated preoperatively for a few days during which time attention was given to diet-insulin balancing and the administration of fluids—at least 3,000 cc. daily unless contra-indicated. During the first 48 hours following operation, glucose in normal saline solution was given intravenously—usually morning and night. An attempt was made to moderately control any glycosuria at this time. With the exception of amputations, which were in most instances done under spinal anesthesia and the intravenous feeding omitted, mouth feeding was started on the third day—in the form of liquid carbohydrate divided into six feedings, two in the morning, two at noon and two at night. From this point on, it was usually possible to keep the urine sugar free and the blood sugar well controlled with insulin. The diet was gradually increased to a maintenance level and sufficient insulin given to control the diabetes. With the acute surgical emergency, haste was frequently essential and much treatment had to be carried out within a short preoperative period. No patient was immediately operated upon who was in a moderate or advanced acidosis, or who was suffering from shock as the result of severe acidosis. It is interesting to see, however, how quickly the patient can be brought under safe control with frequent insulin administration and free use of saline and glucose solution intravenously with the additional aid of blood transfusion in the presence of shock. Following operation, the patient was watched closely for dehydration and the appearance of acetone bodies in the urine, both of which are of more importance than the percentage of sugar in the urine during the first 48 hours. Following this period, in the majority of cases, it was possible to continue as in the uncomplicated case. In no instance did symptoms of coma or severe acidosis appear following the operation.

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[1] Williams, F. W., and O'Kane, T. J.: Mortality in Surgical Diabetes-Criteria and Technique in Extremity Lesions, *Surgery, Gynecology and Obstetrics* 64:956 (May), 1937.

Summary and Conclusion

The results of treatment in 100 surgical diabetics are discussed. The mortality rate was 16%, 10 deaths resulting from amputation of the lower extremity. None of the 16 fatalities were due to primary postoperative infection or to acidosis.

Close coöperation between internist and surgeon is necessary in order to obtain good results. A carefully watched fluid balance, control of the diabetes with diet and insulin and blood transfusions in the presence of shock or severe toxemia are the physician's chief remedies in dealing with the surgical diabetic.

Infectious Mononucleosis (Glandular Fever)

REPORT OF A CASE PRESENTING SYMPTOMS OF ACUTE APPENDICITIS

By R. A. Beliveau, M. D., and Blinn W. Russell, M. D., Lewiston, Maine

It was as late as 1921 that the consistent occurrence of mononucleosis in cases of glandular enlargement and fever became known. Pfeiffer, some years earlier (1889), described an epidemic characterised by irregular fever, non-suppurative enlargement of lymph glands, enlargement of the liver and spleen, and having a uniformly good outcome. He believed the condition to be infectious. In 1896, West described a similar epidemic in America, and Williams one in England in 1897. These earlier reports lacked the essential feature of the blood findings.

From 1907 through 1920 articles appeared presenting cases of glandular enlargement, without suppuration, with irregular fever and showing a marked rise in mononuclear cells in the blood. The condition was given various names and was frequently mistaken for lymphatic leukemia with further confusion because of the favorable outcome as contrasted with the fatal termination of leukemia.

In the study of a major epidemic in Europe in 1928 to 1930, more extensive classification of the blood cells was carried out and, as a result, infectious mononucleosis, glandular fever and monocytic angina are now considered to be different forms or phases of the same disease.

The cause is unknown. Streptococci and the organisms of Vincent's angina appear frequently, but no proof has been forthcoming that any of them are etiological factors. The disease is considered infectious although the incidence of contagion appears very low. It is a rare condition in individuals over 40.

The onset is characterised by fever, headache and malaise, followed by sore throat, glandular enlargement and gastro-intestinal symptoms; the last three being variable in sequence and severity.

Any group of glands may be involved, the most constant being the cervical, and of these the chains posterior to the sterno-cleido-mastoid muscles. Axillary and inguinal glands are frequently involved. Enlargement of the mediastinal or mesenteric glands may produce pressure symptoms as instanced by the present case. The glands vary from the size of a pea to that of a walnut, they are elastic but moderately firm and are not very tender. The enlargement is not symmetrical and the nodes never suppurate.

The swollen glands, with the irregular fever may be the principal clinical feature in epidemic outbreaks among children, and unless the blood count is noted the diagnosis may not be apparent.

In sporadic cases that are likely to occur in young adults, the adenopathy may be preceded by an apparent follicular tonsillitis which passes on to ulceration and edema of the pharynx. The ulceration and the edema may be extensive and may even present an alarming appearance, but laryngeal obstruction is unknown.

Among older patients the fever may run high, glandular swelling may be delayed in appearance and may not be marked. In fact, it may require diligent search. These cases may show macular or papular rashes sometimes resembling "rose spots."

The spleen is frequently enlarged, the liver sometimes, jaundice is rare.

Epstein and Damashek report a case in which the cerebro-spinal fluid was under increased pressure and contained numerous leukocytes while Logefiel mentions a case where the increase in the cells of the spinal fluid was proportionately similar to that in the blood. "(34 cells of which 30 were lymphocytes.)"

The irregular fever and the subjective symptoms may persist from one to three weeks. The blood findings, the adenopathy and the splenomegaly may persist in some degree for considerable time, even as long as a year. Septic complications do not occur. Hemorrhagic nephritis has occurred.

The essential diagnostic features are found in the blood examination. Here, the white count immediately gives a hint as to what the condition may be, although in less characteristic cases one may be misled and a tentative diagnosis of monocytic leukemia made. One may realise the importance of not confusing the two conditions because patients always recover from infectious mononucleosis while the prognosis is poor indeed in monocytic leukemia.

The numerous mononuclear cells present have a peculiar appearance and American writers usually interpret them as lymphocytes, while certain German authors believe them to be monocytes. Whitby and Britton think they are all monocytes while Tidy is of the opinion that both lymphoid and reticulo-endothelial systems are involved. The more recent literature, however, suggests that both abnormal lymphocytes and immature monocytes occur.

The red count is usually normal and there is no variation in the number and appearance of platelets.

The "heterophile test" (agglutination of sheep's blood) introduced in 1932 by Paul and Bunnel is the one diagnostic feature of infectious mononucleosis and further studies have shown that it may be accepted as specific. The authors claim that a titre of 1;64 or over does not occur in any other condition except, possibly, in a patient who has recently received injections of foreign blood serum.

Without the blood examinations, acute infectious mononucleosis may be mistaken for some acute abdominal crisis, influenza, typhoid, German measles, simple pharangytis, tonsillitis, diphtheria, scarlet fever, Vincent's angina, Hodgkin's disease, tuberculous adenitis, syphilis, acute leukemia, and granulocytopenic angina.

Undoubtedly mild sporadic cases pass for acute pharangytis, tonsillitis, influenza, etc., and the characteristic blood picture is not discovered. The time element is of some significance, and in acute sore throats that persist for some four days or more without amelioration of symptoms, the possible significance of a blood count should not be overlooked.

Treatment is symptomatic and supportive; there is no specific treatment.

Case Report

Miss V. S., age 19.

A well-nourished girl considered to be in perfect health except for present attack. Father and mother living and well, has one younger brother, living and well except for recent sore throat which was presumably a peri-tonsillar abscess.

On February 21, 1938, she began having headache and moderate epigastric pain, which, however, did not prevent her from attending school as usual. On February 25th (5th day) in the morning there were nausea and vomiting and pain in the right lower quadrant of the abdomen. It was stated that on the same evening the temperature was 101 with a pulse rate of about 90. There was some abatement of the pain the following day, but on the evening of February 27th (7th day) the temperature was 102, pulse rate of about 95, and there was considerable pain in the right lower quadrant and in the epigastrium. There was considerable nausea but no vomiting. She stated that she had had no cold, and on response to direct question stated emphatically that she had no sore throat. This last was important as it led the examiner to overlook the angina till two hours later, after the blood count was observed.

The face was slightly flushed, the tongue lightly coated, the lung fields were clear and resonant and the heart sounds were clear and regular. The abdomen was generally tender but only very slightly distended. There was marked tenderness in the right lower quadrant, over McBurney's point, with definite spasm of the right rectus muscle, and rebound pain. The liver and spleen could not be felt and no glands were palpable at that time. The kidney areas were negative to palpation.

Because of the possibility of an abdominal emergency, she was immediately taken to St. Mary's General Hospital and on arrival the blood count was done. The initial white count was 15,000 with 39% neutrophils and 60% mononuclear cells. At the hospital, review of the examination revealed the angina. She again emphatically stated that the throat was "not sore" but inspection revealed the tonsils massively enlarged and closely studded with spots of exudative membrane and beginning ulceration.

On the basis of the blood count and the angina, no operation was done, although the clinical picture of an acute abdomen was disconcerting.

The following day (8th) the tenderness diminished, although the abdominal pain continued. The tonsils were enormously enlarged and ulceration was increasing rapidly but still "no sore throat."

On the 9th day, abdominal symptoms essentially absent except nausea. Horrible appearance of throat on inspection but still "no sore throat."

On the 10th, 11th, 12th days marked aversion to carbohydrates, prostration and acidosis, ulceration of throat still progressing but causing "very little pain," returning epigastric tenderness, spleen questionably palpable. Few inguinal glands palpable on right side. 13th day posterior cervical chain barely palpable on left side.

On the 14th day, which was about the time the rise in mononuclears began slowly to recede (93% of 36,700), the severe pain consistent with the intensity of the angina made a rather abrupt appearance.

During the following week general improvement was observed. No complications followed.

The urine was essentially negative throughout, showing only acetone on two dates. The temperature was irregular, not exceeding 102F. and crossing the normal line four times during 17 days in the hospital. The pulse was little affected except during two days of rather marked prostration and acidosis.

The white blood counts were as follows:

W. B. C.	Neutrophiles	Mononuclears	Eosinophiles
7th day 15,000	39%	60%	1%
8th day 16,500	32%	66%	2%
9th day 17,500	30%	70%	—
10th day 22,500	22%	77%	1%
12th day 33,800	8%	91%	1%
13th day 36,700	7%	93%	—
15th day 27,000	25%	75%	—
18th day 18,400	28%	72%	—
19th day 14,000	30%	68%	2%
24th day 14,900	33%	65%	2%

In all of the blood smears studied, there were persistent mononuclear cells of appearance not encountered in normal blood. These were noticeably of two types: (1) large cells with large bean-shaped nuclei, dark blue cytoplasm and vacuolization. (2) Large cells with large round nuclei, slightly eccentrically placed, and light grayish blue cytoplasm. Several of the cells of either type contained azure bodies.

The neutrophils were mostly of the mature type, although an occasional band cell was noticed.

A swab from the throat, made on the 8th day of the disease and before subjective symtoms of sore throat appeared, revealed "Many fusiform bacilli, several spirillæ and few pneumococci."

A Heterophile Antibody test gave positive agglutination in dilutions of 1:1 to 1:128.

Summary

A general and superficial review of infectious mononucleosis is presented, together with a case which may be of interest because of:

(1) Earlier series of blood counts than is sometimes available with the characteristic monocytosis.

(2) The rather startling simulation of acute appendicitis when first seen.

(3) The absence of pain in the very severe throat ulceration till after the blood changes had begun to recede.

(4) Minimal and late occurrence of palpable lymph glands.

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The President's Page

TO THE MEMBERS OF THE MAINE MEDICAL ASSOCIATION:

Now that our spring session at Bar Harbor is over and I have had ample opportunity to review the transactions, I cannot help but be impressed with the magnitude of such an assembly.

The location was ideal, the attendance a record breaker, the commercial exhibits excellent, and I believe the conferences were well attended.

The management, considering the fact that the hotel had just been opened, did themselves grand, and in spite of the weather, I believe it to be an educational and social success.

Certainly much of the credit should go to the committee who arranged such an outstanding program.

It was a pleasure to attend the Council meetings conducted by the chairman, Dr. Thomas A. Foster, which were short and to the point.

As usual, both meetings of the House of Delegates were long-drawn-out affairs, but after much debating the desired results were accomplished.

The Scientific Session, on Monday afternoon, was well attended and the papers ably presented. Monday evening an unusually large crowd filled the assembly hall and listened to a Symposium on Cancer.

Tuesday evening a capacity banquet hall greeted our Governor, Lewis O. Barrows, who presented the customary fifty-year medals and listened to interesting papers by Dr. G. Allan Craig of Bangor and Dr. Frank H. Lahey of Boston.

Following the banquet a social hour was spent in the lobby, after which many departed for home, others retired to enjoy the solitude of their own apartments.

In closing, permit me to emphasize the fact that an equally good time is in store for us at our fall meeting. In the near future a program designating the time and place will be forwarded to the Secretary of each County Society, and I am asking that this be read before their County meeting, stressing the attendance and their much needed coöperation, in order that our fall meeting may be a success.

W. H. BUNKER, *President.*

Editorial

Report of Advisory Committee on Supply of Medical Care

One of the most important messages ever delivered to the members of the American Medical Association is the report of the above mentioned committee. To properly appreciate the value of this report, every individual physician should carefully read first of all the address by Miss Josephine Roche, Chairman of the Interdepartmental Committee to Co-ordinate Health and Welfare Activities of the Federal Government. Unfortunately Miss Roche was unable, due to prior commitments, to be present at the San Francisco session but her address was presented by Dr. Warren F. Draper, United States Public Health Service, who is a member of the House of Delegates. Working under instructions of the President are the technical committees on recreation, nutrition, crime prevention and parole, and medical care. In the last named committee organized medicine naturally has a special interest and it is also fortunate in the fact that some of the officers of the American Medical Association were present at the National Health Conference held in Washington, July 18, 19 and 20. At this meeting there was presented and discussed the full report of the Technical Committee on Medical Care.

Commenting on the survey of medical needs and supply now being carried out by the American Medical Association, Dr. W. F. Braasch, Chairman, says in part as follows: "It cannot be made too emphatic that this is primarily a survey of the practitioners of this country. . . . It is not of great importance to find out what those who are engaged in teaching or cloistered specialists and institutional doctors think about medical care, and we already know what governmental officials and social workers think. The facts of the situation must come from those who are in direct contact with the actual practice of medicine. We must find out from *them* to what extent reform in medical care is needed and get their opinions as to how it can best be accomplished. If there ever can be a mandate from the American Medical Association to its members, this survey should be so considered. Now that we are definitely committed to the survey, it is up to us to make good; if we do not, *the situation will be most disastrous.*"

The report of the House of Delegates, *Journal of the A. M. A.*, July 2, 1938, emphasizes again that this body merits our support and confidence. As brought out in the address of the speaker, Dr. N. B. VanEtten, autocracy or dictatorship is absolutely impossible, inspired critics to the contrary, and it is to the House of Delegates that the profession correctly places the duty and burden of making the policies obligatory for officers to carry out. Again, at the risk of becoming tiresome, it is urged that every member of the Maine Medical Association read and study the complete report of the organization section of the American Medical Association.

◆

E. H. Bennett, M. D.

Late in June this honored member of the Maine Medical Association, and a past President, celebrated his ninetieth birthday. For over half a century Dr. Bennett has held a merited and enviable position in his home town, Lubec. Always an active supporter of organized medicine he no less brought to the civic problems of his community wise counsel and support. For many, many years he was a constant attendant at County and State meetings; presented before them several papers bearing witness to a keen clinical mind and sound judgment. At a time in life when most men would be content to rest in modest retirement he considered his work undone and willingly accepted calls on his time and strength. The JOURNAL wishes to extend to this friend of many years a renewal of deep affection and high esteem. The profession of medicine in Maine is truly grateful for having a colleague whose life has been so fruitful and most worthy of the honors bestowed upon him.

Committee on Problems of Health Insurance and State Medicine

The Trustees of the American Medical Association are conducting a survey, using the County Societies as a unit, to secure information as to the medical needs in the counties of the United States.

There are nine questionnaires to be filled out. These blanks were sent to the county officers in June with the request that the completed returns should be in or on their way to the American Medical Association by July 1st. The need of accuracy would seem to make this impossible. With the proper use of the several blanks, careful work and tactful contacts, in order that the replies would be the most valuable, more time will be necessary.

This is a desirable piece of work and the Committee on Medical Economics of your State Association bespeak the assistance of every physician in helping to make this survey as complete and accurate as possible.

Your Committee did cover very much the same ground two years ago and the summary of their findings are being sent to the Secretary of the American Medical Association.

This in no way should take the place of the present work. For the sake of uniformity the American Medical Association blanks should be filled out carefully and accurately and with as much dispatch as accuracy will allow and forwarded to Chicago.

Committee on Problems of Health Insurance and State Medicine,

W. E. Kershner,
Chairman.

Maine Medico-Legal Society

The annual meeting of the Maine Medico-Legal Society was held on June 27 at Bar Harbor.

Attorney-General Burkett spoke on various matters concerning the Medical Examiner system. A general discussion followed.

Dr. William H. Watts invited the members to attend a meeting in Boston sometime in October, dealing with various phases of Legal Medicine.

The committee, of which the Attorney General is chairman, is continued for another year.

This committee will consider the advisability of changes in the Medical Examiner system.

Officers elected for the ensuing year were: President, Oscar F. Larsen, Machias; Vice-President, Walter S. Stinchfield, Skowhegan; Treasurer, William Holt, Portland; Secretary, George L. Pratt, Farmington.

G. L. Pratt, *Secretary.*

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County News and Notes

Aroostook

The annual meeting of the Aroostook County Medical Society was held at the Northland Hotel, Houlton, on June 14th, with about thirty members attending. Following a banquet in the early evening, the program was opened by the business meeting. The following officers were elected for the coming year:

President, Oscar Norell, Caribou.

Vice-President, W. V. Kirk, Eagle Lake.

Secretary-Treasurer, A. T. Whitney, Houlton.

Member Board of Censors: H. C. Kimball, Fort Fairfield.

Delegates to Maine Medical meeting: W. B. Gibson, Houlton; H. E. Small, Fort Fairfield.

Alternates: Storer Boone, Presque Isle; A. T. Whitney, Houlton.

Four physicians joined the Society at this session: Dr. Leonid Toussaint, Ft. Kent, Dr. F. C. Coleman, Eagle Lake, Dr. George Ebbett and Dr. Lloyd Berrie, Houlton; the three former were elected to membership and the latter was transferred from the York County Medical Society.

The first speaker on the program was Dr. Allan Craig of Bangor, Superintendent of the Eastern Maine General Hospital, who spoke on "The Standardized Hospital and Its Benefit to Doctor and Patient." He outlined the various requirements of the standardized hospital and its adaptability in rural sections. It was a most interesting paper and was followed by considerable informal discussion.

Dr. Arch H. Morrell, State Department of Health, then addressed the meeting on "Interpretation of the More Common Laboratory Procedures." It was ably presented and clarified many points arising in the laboratory work on patients.

The closing speaker of the evening was Dr. Frederick D. Motts, Assistant to the Medical Director of the Farm Security Administration. Dr. Motts of Washington, D. C., is in Aroostook in the interest of the eighteen hundred farm families which are in need and which come under this department. He spoke at length on the system devised to secure medical aid for these people. No definite action was taken by the Society, but a committee was appointed to study the proposition and report at a future date.

Meeting was adjourned at eleven P. M.

Respectfully submitted,

Arthur T. Whitney,
Secretary-Treasurer.

Washington

The May meeting of the Washington County Medical Society was held at the Elks home in Eastport, May 26, 1938.

The meeting was called to order at 2.30 P. M. by President Walter J. Gilbert of Calais.

Minutes of the last meeting were approved as read.

The first paper of the afternoon was given by Dr. Donald Porter of St. John, N. B. Subject: "Intracranial injuries of the New Born."

Many points of unusual interest were dwelt upon by Dr. Porter, and new methods of treatment recommended for some of the simple and often unrecognized injuries to which the New Born is sometimes subjected.

Dr. Allen Joslin of Boston next gave an informal talk on "Diabetes."

Dr. Joslin gave a short history of the disease, older methods of treatment and the astounding effects of the discovery of insulin. He paid a very gracious tribute to Dr. Charles Best, co-discoverer of insulin. He, then, gave in a very interesting and instructive manner an outline of the present day management of the diabetic patient, as followed at the Joslin clinic.

Many questions were asked by members present, and a general discussion followed.

The newer insulins and their use in everyday practice was thoroughly gone over.

A rising vote of thanks was given to Drs. Porter and Joslin for their kindness in appearing before our Society.

The members present were: Drs. Gilbert, Crane, Bunker, Cobb, E. H. Bennet, D. F. Bennet, H. H. Best, Mundie, Bates, Everett, Hanson, Thomas, Metcalf, Murphy, Miner and Larson.

Respectfully submitted,

Oscar F. Larson, M. D.,
Secretary.

Piscataquis, Aroostook, Somerset, Kennebec and Penobscot County Medical Associations Hold Joint Meeting

A joint meeting of the Piscataquis, Aroostook, Somerset, Kennebec, and Penobscot County Medical Associations was held at Squaw Mountain Inn on July 21st. About 70 members and guests sat down to a most excellent dinner at 1.30. Following dinner W. H. Bunker, President of the Maine Medical Association, spoke briefly of the ethics of M. D.'s regarding their conduct with others who practice the art of healing. He also spoke regarding the care that should be taken in making the return to the A. M. A. on the availability of medical care.

George L. Pratt, President-elect of the Maine Medical Association, was next called on. Dr. Pratt's response was very brief.

P. L. B. Ebbett, Councilor for the sixth district, was next called on. Dr. Ebbett spoke regarding the medical survey just completed in Aroostook County and urged that care be taken in making our return to the A. M. A.

Dr. E. D. Humphreys, President of the Somerset County Medical Association, was next called on. Dr. Humphreys extended greetings from Somerset County. Dr. Kagan, President of Kennebec County Medical Association, brought greetings from Kennebec County.

R. H. Aldrich, of the faculty of the Harvard Medical School, was called on. Dr. Aldrich spoke on the *Aniline Dyes Treatment of Burns.* We hope that a write-up of this talk will soon be published in the Maine Medical Journal. Only those who attended the meeting, however, will have had the privilege of enjoying the slides which illustrated Dr. Aldrich's talk and the delightful manner in which the talk was delivered.

Respectfully submitted,

N. H. Nickerson,
Secretary.

New Members

Aroostook

F. T. Coleman, M. D., Eagle Lake.
George Ebbet, M. D., Houlton.
Leonid Toussaint, M. D., Fort Kent.

Oxford

Albert P. Royal, M. D., Rumford.
Joseph A. Villa, M. D., South Paris.
P. A. Ancoin, M. D., Rumford.

Removal Notice

George E. Sullivan, M. D., announces his removal from Oxford to Preble Street, Bingham.

Herbert E. Milliken, M. D., announces his removal from 696 Congress Street, Portland, to Surry, Maine.

Coming Meetings

Cumberland-York

Cumberland and York County Medical Societies will meet Wednesday, August 24, 1938, at Cushing's, Ponce's Landing, Long Island. Boat leaves Casco Bay Wharf (foot of Pearl Street, opposite Custom House) at 2.00 P. M. Returns at 6.15 P. M.

Occasion: Old Fashioned Clam Bake.

Vermont State Medical Society, Burlington, October 6-7. B. F. Cook, Rutland, Secretary.

Notices

Tumor Clinics*

Portland: *Maine General Hospital*—Thursday, 11.00 A. M.-12.00 M. Director, *Mortimer Warren, M. D.*

Lewiston: *Central Maine General Hospital*—Tuesday, 11.00 A. M.-12.00 M. Director, *E. V. Call, M. D.*

St. Mary's General Hospital—Wednesday, 4.00 P. M. Director, *R. A. Beliveau, M. D.*

Waterville: *Thayer Hospital*—Thursday, 9.00-11.00 A. M. Director, *Edward H. Risley, M. D.*

Sisters' Hospital—Thursday, 9.00-11.00 A. M. Director, *Blynn O. Goodrich, M. D.*

Bangor: *Eastern Maine General Hospital*—Thursday, 11.00 A. M.-12.00 M. Director, *Magnus F. Ridlon, M. D.*

* Approved by Maine Medical Association.

Services to Crippled Children Clinic Schedule

Rumford: *Rumford Community Hospital*—1.00 P. M., 3.00 P. M., Wednesday: August 17th, October 12th, November 30th.

OR

Rumford Community Hospital—1.00 P. M., 3.00 P. M., Wednesday: August 17th, October 12th.

Machias: *Washington State Normal School*—1.00 P. M., 3.00 P. M., Tuesday: October 4th.

Lewiston: *Central Maine General Hospital*—9.00-11.00 A. M., 1.00-3.00 P. M., Saturday: August 27th, September 24th, October 22nd, November 19th, December 17th.

Bangor: *Eastern Maine General Hospital*—1.00 P. M., 3.00 P. M., Thursday: August 25th, September 22nd, October 20th, November 17th, December 15th.

Portland: *Children's Hospital*—9.00-11.00 A. M., 1.00-3.00 P. M., Monday: September 12th, October 10th, November 14th, December 12th.

Presque Isle: *Northern Maine Sanitorium*—9.00-11.00 A. M., 1.00-3.00 P. M., Tuesday: August 30th, October 25th, December 6th.

NOTE: Clinic notices will determine which schedule is being followed.

This schedule is subject to change at any time. If changes are made interested workers will be notified.

No Clinic appointments can be made for patients during the last five days prior to the Clinic except for cases who are referred in directly by physicians.

American Board of Obstetrics and Gynecology

The next written examination and review of case histories of Group B applicants by the American Board of Obstetrics and Gynecology will be held in various cities of the United States and Canada on Saturday, November 5, 1938. Last date for applying is September 5, 1938.

The next general examination for all candidates (Groups A and B) will be held in St. Louis, Missouri, in June, 1939, immediately prior to the American Medical Association meeting.

Application blanks and booklets of information may be obtained from Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania. Applications for these examinations must be filed in the Secretary's Office not later than sixty days prior to the scheduled dates of examination.

American Association for the Study of Goiter

The annual meeting of the American Association for the Study of Goiter for this year will be held in Washington, D. C., September 12, 13 and 14 in conjunction with the Third International Goiter Conference. A final program will be available at the time of the meeting and will be distributed to all attending physicians at the registration desk on the morning of September 12. Headquarters, Mayflower Hotel.

W. BLAIR MOSSER, M. D.,
Corresponding Secretary.

American Congress of Physical Therapy

The 17th annual scientific and clinical session of the American Congress of Physical Therapy will be held coöperatively with the 22nd annual convention of the American Occupational Therapy Association, September 12, 13, 14 and 15, 1938, at the Palmer House, Chicago. Preceding these sessions, the Congress will conduct an intensive instruction seminar in physical therapy for physicians and technicians, September 7, 8, 9 and 10.

The convention proper will have numerous special program features, a variety of papers and addresses, clinical conferences, round table talks, and extensive scientific and technical exhibits.

The instruction seminar should prove of unusual interest to everyone interested in the fundamentals and in the newer advances in physical therapy. The faculty will be comprised of experienced teachers and clinicians; every subject in the physical therapy field will be covered. Information concerning the convention and the instruction seminar may be obtained by addressing: The American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago.

Book Reviews

"Textbook of Pathology"

Edited by E. T. Bell, M. D., Professor of Pathology in the University of Minnesota, Minneapolis, Minn. Contributors: E. T. Bell. M. D., Professor of Pathology in the University of Minnesota, Minneapolis, Minn; B. J. Clawson, M. D., Professor of Pathology in the University of Minnesota; Hal Downey, Ph. D., Professor of Hematology in the University of Minnesota; J. S. McCartney, M. D., Associate Professor of Pathology in the University of Minnesota; C. J. Watson, M. D., Associate Professor of Medicine in the University of Minnesota. Third Edition, Enlarged and Thoroughly Revised. Published by Lea & Febiger, Philadelphia, 1938. Price: $9.00.

The authors have thoroughly revised the material presented in the previous edition. Much new material has been introduced. Over fifty new illustrations and more than one hundred and twenty-five pages have been added to the text, thus bringing the total number up to four hundred and twelve, and eight hundred and ninety, respectively This work is so constructed that it will serve the medical student admirably as a reliable companion in the study of clinical medicine and as a stimulant to continue his investigation in the various fields of human pathology. Any study of human pathology which recognizes the fact that "our mental capacity as well as the physical form of our bodies is dependent almost entirely on inheritance and likewise many of the defects and diseases from which we suffer have their basis in heredity," promises to create for itself and its students the notion that it is a living science destined to point to ways and means that will help the medical profession to work more successfully toward better health for future generations. The authors present a well-balanced, comprehensive, authoritative, and clearly descriptive and practicable text.

"Essentials of Psychiatry"

By George W. Henry, Associate Professor of Psychiatry, Cornell University Medical College, New York; Attending Psychiatrist, The New York Hospital, New York. Third Edition. Published by The Williams and Wilkins Company, Baltimore, 1938. Price: $5.00.

The rapid progress which is being made at the present time in the field of psychiatry requires frequent revisions of formal presentations of its leading theories as well as its practices. Psychiatry has become as scientific as any other branch of medicine but psychiatry, perhaps more than any other branch of medicine, due to its complexity, meets with much misinterpretation and erroneous application of its basic and scientifically correct principles.

To all appearances the author of this work has succeeded in creating an American textbook on the essentials of psychiatry which is almost free of ambiguous terminology and grossly conflicting theories. The fact that it is already in its third edition is proof that it fills a great need and that it is well liked. The book is written for every member of the medical profession who deals with the mental problems of his patients. In clear language the salient features of mental aberration are presented and illustrated with typical case records. Physicians who do not yet know of this work and who may judge from the title that it deals with problems of insanity only will be quickly convinced by perusing the chapter headings that there are many sections which deal with problems with which he must deal constructively every day while practicing medicine. Merely enumerating them is stimulating; they are: Personality Development; Personality Disorders; Classification; Affective Psychosis; Paranoia and Paranoid Psychosis; Schizophrenic Psychosis; Psychoneuroses; Toxic Psychoses; Organic Psychoses; Constitutional Deficiency; Method and Purpose of Mental Examination; Principles of Treatment; Psychiatric Nursing; Psychopathology of the Normal; Mental Hygiene; Disorders of Childhood; Psychiatric Social Service; Medico-legal Aspects; Psychiatry in General Hospital Practice; Psychiatric History.

When it is fully realized that "Psychiatry is a branch of medicine dealing with the study and treatment of disorders which involve the attitude, behavior and thinking of an individual and which are motivated by instinctive and emotional conflicts," and when it is clearly understood that the "careful study of patients having affective psychoses reveal the fact that they are fundamentally insecure and that their insecurity is related to conflicting feelings of affection and hatred," it ought to be of great benefit to everyone to be reminded again that "Each person is constantly striving to dominate his environment," and that "In the struggle to dominate the environment many devices have been elaborated by which the frank recognition or the expression of actual conditions is avoided," and that "All people obtain pleasure from the fanciful gratification of vain longing," then everyone will tend to feel more kindly toward those who have somehow failed to fully comply with the often rigid dictates of our modern social requirements.

Every practicing physician meets with people who consider themselves "normal" but are not, and need his help, many others who are filled with many fears, especially the fear of being on the verge of a "nervous breakdown" or worse who also must be helped. Dr. Henry successfully covers the entire range of possibilities of the patient's states of mind in readily understandable language and presents appropriate and approved methods for dealing with every patient's problems individually in his home or in the doctor's office wherever this is practicable and beneficial for the patient.

"Mental Therapy"

By Louis S. London, M. D., Formerly Passed Assistant Surgeon (R), United States Public Health Service; Medical Officer, United States Veterans' Bureau; Assistant Physician, Central Islip State Hospital, Central Islip, New York, and Manhattan State Hospital, Wards Island, New York. Covici-Friede, Publishers, New York City, 1938. Price, $12.50.

Dr. London's two-volume work entitled Mental Therapy is unique in this country. Since 1913 he has been active in the field of psychoanalysis, originally as a close follower of Freud but now apparently leaning more toward the modifications of Freud's theories as experienced by Stekel. With the help of these fifty more or less completely reproduced case histories, the author tries, and apparently succeeds, to show convincingly that "Psychoanalysis has shed a bright light on the injurious effect of the deviations of the sex instinct and their effect on life happiness and moral development. Modern pedagogy has to take into serious account the sexual makeup of the child, which was previously ignored. It forbids the excessive fondling of which ungratified husbands and wives are often guilty. It warns against allowing children after their first year to sleep in the same room with parents and against allowing growing children to overhear their parents' intimate relations. Many an obsessional neurosis, hysteria, and even schizophrenia can be traced to a premature awakening of the sexual instincts of the child."

The work is divided into six parts, entitled: I. Metapsychology; II. Psychogenesis and Psychotherapy of the Neuroses; III. The Paraphiliac Neurosis; IV. Psychogenesis and Psychotherapy of the Borderline Neuroses; V. Psychogenesis and Psychotherapy of the Psychoses (Schizophrenia); VI. Psychogenesis and Psychotherapy of the Psyhoses (cyclic).

This author believes that beneficial results can be obtained by psychotherapeutic methods; he believes that all cases should enjoy the privilege of having psychotherapeutic methods tried before custodial care is resorted to; he believes that psychoanalysis has opened new avenues of vision concerning the psychogenetic causes of mental disease; he believes and strongly recommends that "no one but a psychiatrist, preferably one trained in mental hospitals, should try to delve into psychiatric mechanisms." His beliefs are based on twenty-five years of practice in mental diseases.

"Practical Otology, Rhinology and Laryngology"

By Adam Edward Schlanser, M. D., Colonel, Medical Corps, United States Army; Chief of the Eye, Ear, Nose and Throat Service, Letterman General Hospital, San Francisco, Calif.; Former Director of the Department of Ophthalmology and Otorhinolaryngology, Army Medical School; and Chief of the Eye, Ear, Nose and Throat Section, Walter Reed General Hospital, Washington, D. C.; Member of the Association of Military Surgeons of the United States, Fellow of the American College of Surgeons and of the American Academy of Ophthalmology and Otolaryngology; Chevalier of the Legion of Honor. Published by Lea & Febiger, Philadelphia, 1938.

The author of this book was led to its creation by the desire to present reliable, easily available information and definite instruction for handling, expeditiously and confidently, every one of the many complaints which are or may become routine occurrence to the medical practitioner specializing in otorhinolaryngology. It is a work intended to be used in clinical practice and does not contain data of history, anatomy, physiology and detailed symptomotology, because it is assumed that such fundamental information has been acquired by the practitioner previous to specialization. The work is based upon peace-time practice and is readily adaptable to civilian or private practice. The names of the diseases dealt with in this text conform with the nomenclature employed in military practice. The author's special effort was directed to presenting only that which he considers important and useful and has been proven to be successful by actual extensive practical experience.

"Taylor's Practice of Medicine"

Fifteenth Edition. By E. P. Poulton, M. A., D. M. Oxon., F. R. C. P. Lond. With the assistance of C. P. Symonds, M. A., D. M. Oxon., F. R. C. P. Lond.; H. W. Barber, M. A., M. B. Camb., F. R. C. P. Lond.; R. D. Gillespie, M. D. Glas., F. R. C. P. Lond., D. P. M. Lond.; N. Hamilton Fairley, O. B. E., M. D. D. Sc. Melb., F. R. C. P. Lond.; W. M. Mollison, C. B. E., M. Ch. Camb., F. R. C. S. Eng. Published by William Wood & Company, Baltimore, 1936. Price, $8.50.

For forty-six years, Sir Frederick Taylor's "Practice of Medicine," now in its fifteenth edition, has been the accepted standard of the medical profession of the British Empire and other English speaking countries. The original attempt of Sir Frederick Taylor, like that of Sir William Osler, to bring all worthwhile and absolutely necessary information which is required for the practice of medicine into one volume has been adhered to in all of the fifteen editions. As a consequence of this aim, the book is fully stocked with conservative and well tried, sound advice. The adherence to this plan prevented the inclusion of many of the new and ultramodern methods of treatment, with their often very elaborate mechanisms and techniques. Nevertheless, when one realizes that in this book is surveyed the total range of medical diseases: General Medicine; Diseases of the Nervous System; Diseases of the Skin; Mental Diseases; Diseases of the Tropics; Diseases of the Nose, Throat and Ear, with all their ramifications, Taylor's Practice of Medicine is still a masterpiece among medical textbooks.

"A Synopsis of the Diagnosis of the Acute Surgical Diseases of the Abdomen"

By John A. Hardy, B. Sc., M. D., F. A. C. S., El Paso, Texas. Published by the C. V. Mosby Company, St. Louis, 1938. Price, $4.50.

With this book the medical profession is presented with another member of the now famous and apparently very well received Mosby Synopsis group. This author has tried to bring together into small space every proved means of diagnosis of the acute surgical diseases of the abdomen. He places special emphasis on recognition and diagnostic application of signs and symptoms of diseases that may be seen or felt or heard, and illustrates these very instructively both verbally and with the help of ninety-two descriptive illustrations.

"Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1937"

Printed by the American Medical Association, Chicago, 1938.

This small volume contains reprints of reports of the Council which were adopted and authorized for publication during 1937. There are several extensive reports on such preparations as Benzedrine Sulphate; Avertin with Amylene Hydrate; Edwenil; Entoral; Evipal; Histidine Hydrochloride, etc., and a report on the present status of the sterility of catgut sutures on the American market. These articles, which were previously published in the Journal of the American Medical Asociation, are here brought together for quick reference in a convenient form.

"The Romance of Proctology"

By Charles Elton Blanchard, M. D. Published by Medical Success Press, Youngstown, Ohio, 1938. Price, $4.50.

Looking back in medical history, reference to proctologic medicine and surgery is rare. Dr. Blanchard here presents some of the highlights in this history. He traces the course of the developmental progress of proctology as a part of medical and surgical service to man afflicted with rectal diseases. Peculiarly enough, all orifices of the human body have been examined, explored, studied and treated and recorded in print by physicians, but specific literature on proctologic work was practically absent before the days of Dr. Frederick Salmon (1796-1868), the founder of St. Mark's Hospital in Bath, England. Proctology as a specialty in America did not enter medical history until Dr. Joseph M. Mathews (1847-1928) began to treat diseases of the rectum as a specialty. The author of *The Romance of Proctology*, after presenting the various historic epochs, with their pioneers, shows by contrast and comparison the difference between ambulant and surgical proctology. He believes that hemorrhoids of all types, nearly all fistulas, pruritis anus, as well as many minor pathologic afflictions of the anus and rectum, can be treated by the ambulant method for best results.

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RECENT ADVANCES IN THE SCIENCE OF NUTRITION

I. THE ROLE OF RIBOFLAVIN IN HUMAN NUTRITION

● In 1933, a series of articles on the vitamins was published, each article written by an authority in the field of nutrition. These papers served to summarize existing knowledge concerning these essential factors. During 1938 a similar series of articles has been issued. Comparison of related papers in these two series will indicate the most important advances in the science of nutrition which have been made in the course of the past five or six years.

In the first series of articles mentioned above, only two of the better known members of the old vitamin B complex received extended discussion (1). The more recent series, however, is characterized by the inclusion of a number of papers on riboflavin which, since 1932, has assumed a new significance in human nutrition (2). As compared with other factors with which it is often associated in nature, the rise of riboflavin to importance in human nutrition is somewhat anomalous.

For example, the effects upon humans of severe dietary deprivation of vitamin B_1 and the P-P factor are well known, in fact, such effects in themselves afford proof of the indispensable nature of these factors. While riboflavin is apparently concerned in cellular oxidation processes of mammals, the specific effect on humans of riboflavin deficiency is not known. Nevertheless, from the weight of evidence accumulated during the last five years, riboflavin is generally accepted as important in human nutrition. Authoritative opinion concerning riboflavin has been succinctly expressed as follows:

> "The fact that we do not know any specific human disease due to shortage of riboflavin is entirely compatible with the view that this substance is important in human nutrition. A detailed discussion of reasons for believing that riboflavin plays a role in the life process of the human as of other species would probably seem superfluous to a majority of readers at this date, and to a still larger majority in the future. Suffice it to point out that our species has evolved in the direction not of shortening the list of things it needs but of lengthening the list of things it can use to advantage." (2c)

Chemically, riboflavin is described as 6, 7 dimethyl-9 (d-l' ribityl) iso-alloxazine; a yellow-green, heat-stable pigment enjoying wide distribution in the plant and animal kingdoms. Many foods, therefore, of both plant and animal origin supply valuable amounts of this essential factor, specifically, fruits, vegetables, particularly the leafy pigmented types, and animal products such as milk and dairy products, meats, liver, and fish. It may, perhaps, be too early to estimate the daily human requirement for riboflavin. However, one rather liberal recommendation lists 600 units* as required daily by older children and adults; the estimated riboflavin requirement for younger children is somewhat less (2c).

In view of the above facts, attainment of an adequate intake of riboflavin would appear to be best insured by a varied dietary regime which includes the so-called "protective" foods. In the formulation of such diets, commercially canned foods may be particularly valuable. The older "vitamin G" assays —which are now known to measure principally the riboflavin contents of foods—indicate that modern canning procedures are without significant effect upon riboflavin. In addition, many foods valued for their contribution of this factor are canned commercially and hence are conveniently available at all seasons on practically every American market. Therefore commercially canned foods may be freely used in arranging such protective diets and they should materially assist in providing an adequate supply of this newly recognized dietary essential, riboflavin.

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*Bourquin-Sherman.
1. 1932. J. Amer. Med. Assn. 98, 2201 and 2283
1932. Ibid. 99, 26 and 121.
2a. 1938. J. Amer. Med. Assn. 110, 1105.
b. 1938. Ibid. 110, 1188.
c. 1938 Ibid. 110, 1278.

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Clinical observations of Strauss and McDonald lead to the conclusion that the condition is a dietary deficiency disorder similar to beriberi, caused by lack of vitamin B_1, complicated by symptoms which may be traced to shortage of vitamin G. They report recovery in their cases receiving this therapy, including dried brewers' yeast.

Hyperemesis as Cause of Avitaminosis

Wechsler observes that all cases of polyneuritis of pregnancy recorded in the literature were preceded by long periods of severe vomiting. "It would seem," he adds, "that because of actual starvation these patients suffered from avitaminosis and consequent neuritis," a view likewise held by Hirst, Luikart, and Gustafson. Plass and Mengert observe that the practice of giving high carbohydrate feedings for hyperemesis gravidarum is still more likely to cause avitaminoses B and G.

Dried brewers' yeast, as it is far richer than any other food in vitamins B_1 and G, is being used with benefit both in the prevention and treatment of polyneuritic symptoms of pregnancy. Lewy found that additions of yeast to the diet reduced electric irritability of the peripheral nerves and brought clinical improvement. Vorhaus states that he and his associates, after administering large amounts of vitamin B_1 to 250 patients having various types of neuritis, including that of pregnancy, observed in about 90% of cases "varying degrees of improvement, i.e., from partial relief of pain to complete disappearance of all symptoms."

Need for Vitamins B and G in Lactation

Evans and Burr, Hartwell, Sure and co-workers, and Macy *et al* are among numerous authorities who find that the nursing mother also needs supplements of vitamins B_1 and G, from 3 to 5 times the normal requirement. Tarr and McNeile report that the physical, mental, and emotional status of 120 pregnant and lactating women receiving Mead's Brewers Yeast and other foods high in vitamin B was superior to that of a control group of 116 women.

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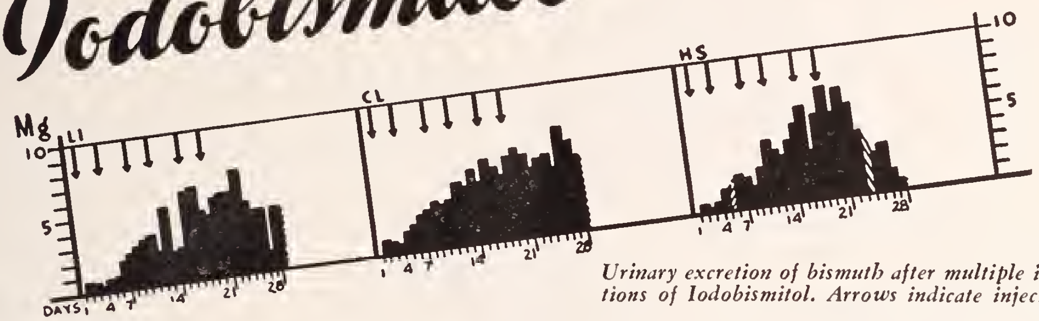

Urinary excretion of bismuth after multiple injections of Iodobismitol. Arrows indicate injections

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[1] Sollmann, T., Cole, H. N., Henderson, K., *et al.: Amer. J. Syph., Gon. & Ven. Dis.* 21:480 (Sept.), 1937.

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Maine Medical Journal

The Official Organ of

The State and County Medical Societies

Vol. XXIX *Portland, Maine, September, 1938* *No. 9*

*Acute Respiratory Infections—The Upper Respiratory Tract**

By Frederick T. Hill, M. D., and Edwin R. Irgens, M. D., Waterville, Maine

The subject of this symposium, "Acute Respiratory Infections," automatically excludes chronic and non-infectious diseases and limits our discussion to acute infections of the regions lined by respiratory mucous membrane. Our part in the symposium is confined to a consideration of the upper respiratory tract; the nasal cavities and paranasal sinuses, the middle ear and mastoid, the nasopharynx and pharynx, and the larynx and trachea. No reference will be made to the bronchi, other than to suggest the value of diagnostic bronchoscopy in certain obscure cases, and the value of bronchoscopic treatment in early lung abscess and as a possible adjunct to the management of impending atelectasis.

It is important to bear in mind that this whole respiratory tract, from the nasal vestibules to the pulmonary alveoli, is lined with mucous membrane, homologous in type, differing histologically in different regions, it is true, but fundamentally similar and continuous throughout.

In the nose the epithelium is of the stratified ciliated columnar variety, consisting of tall ciliated surface cells with irregular columnar basal cells between. Numerous mucous-containing goblet cells may also be found. The nasal fossae communicate with the paranasal sinuses whose lining membrane resembles that of the nose itself, except for being much thinner. It is of the ciliated columnar type with a delicate basement membrane and a tunica propria, poor in elastic fibers and inseparately blended with the periostium, of which it is a part. The epithelium lining the Eustachian tubes is of the stratified ciliated columnar type similar to that found in the nose. This is modified in the tympanum, or middle ear, to the simple low cuboidal type, although in places it may be ciliated, and sometimes assume a pseudostratified character. The pharyngeal epithelium in the region of the posterior nares is similar to that of the nasal cavities, but soon changes to the stratified squamous form. This latter type is likewise found covering the vocal cords, the laryngeal surface of the epiglottis and the anterior surfaces of the arytenoid cartilages. Elsewhere in the larynx, and extending down and lining the trachea, we find the stratified ciliated columnar type of epithelium.

This wide distribution of respiratory mucous membrane extends from the nasal cavities out into the paranasal sinuses, up the Eustachian tubes to the tympanic cavities and down the larynx and trachea to the bronchi, bronchioles and alveoli. But for certain exceptions where it becomes modified to the stratified aquamous form in the pharynx and part of the larynx, this is ciliated epithelium, with the cilia constantly beating in the direction of the pharynx, backward in the nose and upward in the trachea. This membrane is covered with a constantly moving and changing film of mucous, the first line of defense of this respiratory tract. It has been likened to a "self-cleaning carpet." Contrary to usual opinion, these ciliated cells are quite resistant and capable of functioning under most adverse circumstances. Microscopic studies have shown them active eleven hours after conscious death of an individual.

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* Read before the 1938 Annual Session of the Maine Medical Association, June 27, 1938.

Faulty cranial development, possibly due to endocrine dyscrasias and resulting in anatomical abnormalities, poor living habits, the too dry air of overheated houses, and allergic states, may predispose towards infections of the sinuses. Nasopharyngeal pathology and violent nose-blowing may precipitate middle ear infections, and tonsillar tissue may act as foci of infection. Gravity, incident to Man's assumption of an upright position, both impedes the natural drainage of the sinuses and of the thoracic respiratory tract, and allows the direct dumping of infective material from above into the pulmonary airways. Under these circumstances the first line of defense may be penetrated, and the cilia overwhelmed, so that reliance must then be placed upon the histeocytic response of the reticulo-endothelial system. How to stimulate this to most effectiveness would seem to be our greatest problem, a goal not yet reached. In the field of the upper respiratory tract, at least, our efforts are largely mechanical, in endeavors to promote drainage. Ill-advised and illogical therapy may serve to impede, or even defeat, the natural defense mechanism. Too much empiric treatment of the Past has been of this character. In sulphanilamide, however, we have a drug which, when properly used, with due consideration of its possible effect upon the blood-forming system, bids fair to eliminate a certain proportion of serious complications, such as meningitis, sinus thrombosis, laryngeal edema, etc. This seems to exert its effect through mobilization of the defensive cytological mechanism of the body, and is a most valuable adjunct to our therapeutic armamentarium.

While the emphasis of this afternoon's discussion is placed upon thoracic infection, it is likewise important to devote some consideration to the areas above the clavicle, as the etiology of acute thoracic respiratory disease is frequently found in infection in the upper tract; such as an acute cold or sinusitis, tonsillitis, or an acute exacerbation of a chronic sinusitis. Pulmonary involvement may occur by aspiration, by continuity, by the blood stream, or by the lymphatics.

At times the reverse may be true and complications in the upper respiratory tract may occur secondarily to an infection below. The formerly accepted theory that bronchiectasis was secondary to sinus infection would seem to be exploded by the recent work of Goodale which shows that at least half of these cases, especially in children, are due to pneumonia. There is also a distinct possibility that sometimes the sinuses may become secondarily involved by infective material raised from bronchiectatic cavities. We should recognize the possibility and frequency of middle ear involvement secondary to some pulmonary infection, such as pneumonia, where the infection travels up the Eustachian tube. Unfortunately these cases are too often overlooked, probably because pain may be absent. Possibly the patent may be too sick to manifest normal pain reactions. Examination may show a dull drum, somewhat swollen, dead white except for redness along the handle of the malleus and in Shrapnell's membrane, an incision usually reveals thick pus in the middle ear. Lack of pain does not rule out an otitis media. The one symptom of most diagnostic value in these cases is deafness. A normal properly functioning ear hears. This same condition may hold true for any severe infection where there is marked prostration and depression of normal reactivity. Unrecognized and consequently untreated otitis media of this type undoubtedly accounts for a surprisingly large percentage of our so-called chronic progressive deafness in later life.

The Acute Cold—This is undoubtedly the commonest and most universal affliction of mankind and about the least understood; the greatest single cause of disability and the common forerunner of most forms of acute respiratory infections. Probably due to a filterable virus with secondary bacterial involvement, there seems to be little that is consistently and logically effective in the way of prevention. Lowered general resistance, fatigue, constipation, over-indulgence in eating and drinking, and bodily chilling all play important etiological roles. Generally an individual knows the usual cause of his own colds. Perhaps the best preventive measure is to have backbone enough to act on one's own experience and avoid whatever seems to predispose towards colds. While many physicians seems to possess great faith in the efficacy of vaccines, there is actually little scientific basis for this, although any foreign protein given parenterally may increase the hemipoietic response. But one cannot vaccinate against fatigue, drafts, poor ventilation or over-indulgence. Once contracted, the cold usually runs its course and, unless complications occur, is given little consideration. It is becoming generally realized, however, that the common cold is responsible for many later degenerative conditions affecting, among other things, the internal ear, the sinuses and the cardio-renal system. The most effective treatment is bedrest, if it is possible to encompass it, general medical care, avoidance of heavy nose-blowing and a nasal spray of a watery solution of ephedrine to relieve nasal congestion.

Acute Sinusitis—This is usually secondary to an acute cold, although it may follow swimming, or occur as a complication of the exanthemata. The symptoms of acute sinusitis are: usually pain—worse at midday, tenderness over the affected sinus, nasal obstruction and discharge. Examination may reveal swollen congested middle turbinates and, in the later stages, a purulent discharge. This latter may not be seen until after the tissues have been shrunk down with cocaine or adrenalin, or suction has been used. Transillumination and X-ray show the sinus to be cloudy. The treatment of acute sinusitis should be very conservative. Operative interference is to be avoided, if possible, and only undertaken when absolutely necessary. Bedrest, adequate fluid intake, shrinking sprays, general medical care, the use of opiates and the infra-red lamp for pain, and occasionally gentle suction to promote drainage, usually suffice. Rarely, in the later stages, it may be advisable to irrigate the antra. When this procedure is indicated it is preferable to try to employ the natural ostia rather than puncture. Occasionally it may be necessary to remove the anterior end of the middle turbinate, or open the agger nasi cell, and the rare fulminating case may demand external operation. But conservatism should be followed as much as possible in every case of Acute Sinusitis.

Chronic Sinusitis—is mentioned only as a frequent etiological factor in acute pulmonary disease. In itself it may manifest few symptoms that the patient is aware of. The most significant is post-nasal discharge but this is so widespread in the Temperate Zone that it is often overlooked. Pain and headache are not complained of as much as the textbooks would have us believe. Alternating nasal obstruction, frequent so-called colds (more likely acute exacerbations), anosmia, and nasal and post-nasal discharge are all significant symptoms. Nasal examination may reveal a purulent discharge, chronic inflammatory reactions in the turbinates, or polyposis, or these all may be absent. Transillumination is much over-rated. The Roentgenogram is the one most reliable diagnostic aid, provided it is properly done. Unfortunately too few X-ray men are conversant with good Sinus Roentgenology. At least four positions are necessary and the detail of the lining membranes, rather than merely the osseous structure, should be clearly depicted.

Deviation of the Nasal Septum—may predispose towards acute colds and sinus infections through faulty nasal ventilation and drainage. If a septal deviation is sufficient to cause distinct obstruction and there be a tendency to frequent colds or a chronic sinusitis, correction of the condition would seem good preventive medicine.

Epipharyngitis—Under this rather broad term we will group any infection of the nasopharynx—so frequently the initial seat of respiratory disease. If the location of symptoms is any guide, most head colds seem to start here. In the presence of adenoids the possibilities for trouble are numerous and far-reaching; middle ear complications, sinusitis, laryngitis, or involvement of the pulmonary region itself. Good preventive medicine would suggest the desirability of elimination of adenoids when present. For the treatment of acute infection of the nasopharynx, post-nasal applications of methylene blue may be effective if done early, but, as in all acute respiratory conditions, nothing quite equals bed-rest and general medical care.

Acute Purulent Otitis Media—may result from any inflammatory condition of the upper air passages and is therefore a common sequela of the exanthemata and the common cold. It may follow packing of the nose, or nasopharynx, in severe cases of epistaxis, or result from water entering the middle ear during swimming. Violent blowing of the nose may drive infective material into the middle ear. Probably the chief predisposing cause is the presence of adenoids in the nasopharynx. The bacteriology is usually streptococci or pneumococci. At the onset of an attack, pain is the chief symptom. It is generally relieved by perforation, or paracentesis. The membrane tympani loses its lustre, becomes hyperemic and bulges. The handle of the malleus usually cannot be distinguished. Paracentesis should be performed early. While hearing is always markedly impaired, in 80 per cent of cases this returns to normal, especially if proper treatment has been given early.

Mastoiditis and Complications—Mastoiditis is an inflammation of the mastoid process due to infection, and secondary to involvement of the middle ear. Pain is a common symptom, but it varies greatly in degree. Tenderness on pressure over the mastoid may or may not be present. Uncomplicated mastoiditis rarely causes a temperature rise of over 100. Discharge from the ear is generally profuse, and there is usually sagging of the superior canal wall. There is generally edema or periostial thickening over the mastoid, and in children perforation of the cortex may result in a subperiosteal abscess. The Roentgenogram constitues a valuable diagnostic aid. When it is evident that resolution is impossible, or complications seem imminent, a thorough simple mastoidectomy should be performed. The greatest danger, of course, is that of complications. The infection may spread medially to the labyrinth through the oval or round windows; upwards towards the middle cranial fossa resulting in extradural abscess, temporal lobe abscess, or meningitis; backwards to the posterior fossa producing extradural abscess, thrombosis of the lateral sinus, meningitis, cerebellar abscess; or downwards producing thrombosis of the bulb of the internal jugular vein.

Acute Catarrhal Otitis Media—This is produced by extension of a catarrhal inflammation of the nasopharynx along the Eustachian tube to the tympanum. It is commonly found in children having nasopharyngeal obstruction due to adenoids. It may be also associated with common "colds" or new growths in the nasopharynx. There is usually a sense of fullness in the ear. Deafness may be quite marked. Where there is only Eustachian tube obstruction, the drum-membrane may show little change from normal other than indrawing of the handle of the malleus. When the process involves the tympanum it is accompanied by a seromucous exudate and a fluid level may sometimes be seen across the drum-membrane. If the drum is thickened the fluid can be demonstrated only by paracentesis. Undoubtedly some cases are due to allergy. In uncomplicated cases the most satisfactory method of treatment is inflation, but if this method is unsuccessful paracentesis should be done. The cause of the condition in the nose, or nasopharynx, should receive appropriate treatment.

Acute Tonsillitis—is usually a self-limited disease but its complications or sequalæ may be of most serious consequence. The diagnosis rarely causes difficulty, but the importance of taking a culture should be kept in mind. The characteristic follicles may not appear until a day or two after onset of the fever. Local treatment may occasionally be effective, in an abortive way, if carried out early. The importance of bed-rest cannot be overstressed. The shores of Life are strewn with wrecks due to neglected cases of Tonsillitis. General medical care is more important than local treatment.

Lingual Tonsillitis—is quite similar to faucial tonsillitis but is frequently overlooked. This is due to infection of the lingual tonsil and may not be seen unless the patient is examined with the laryngeal mirror. This condition often occurs in tonsillectomized patients.

Tonsillar Abscess—Acute suppuration in the tonsil may be due to the retention of infection in a crypt, or to the spontaneous rupture of a peritonsillar abscess through a crypt. There is a unilateral inflammatory swelling, pain and dysphagia. Its appearance may simulate malignancy.

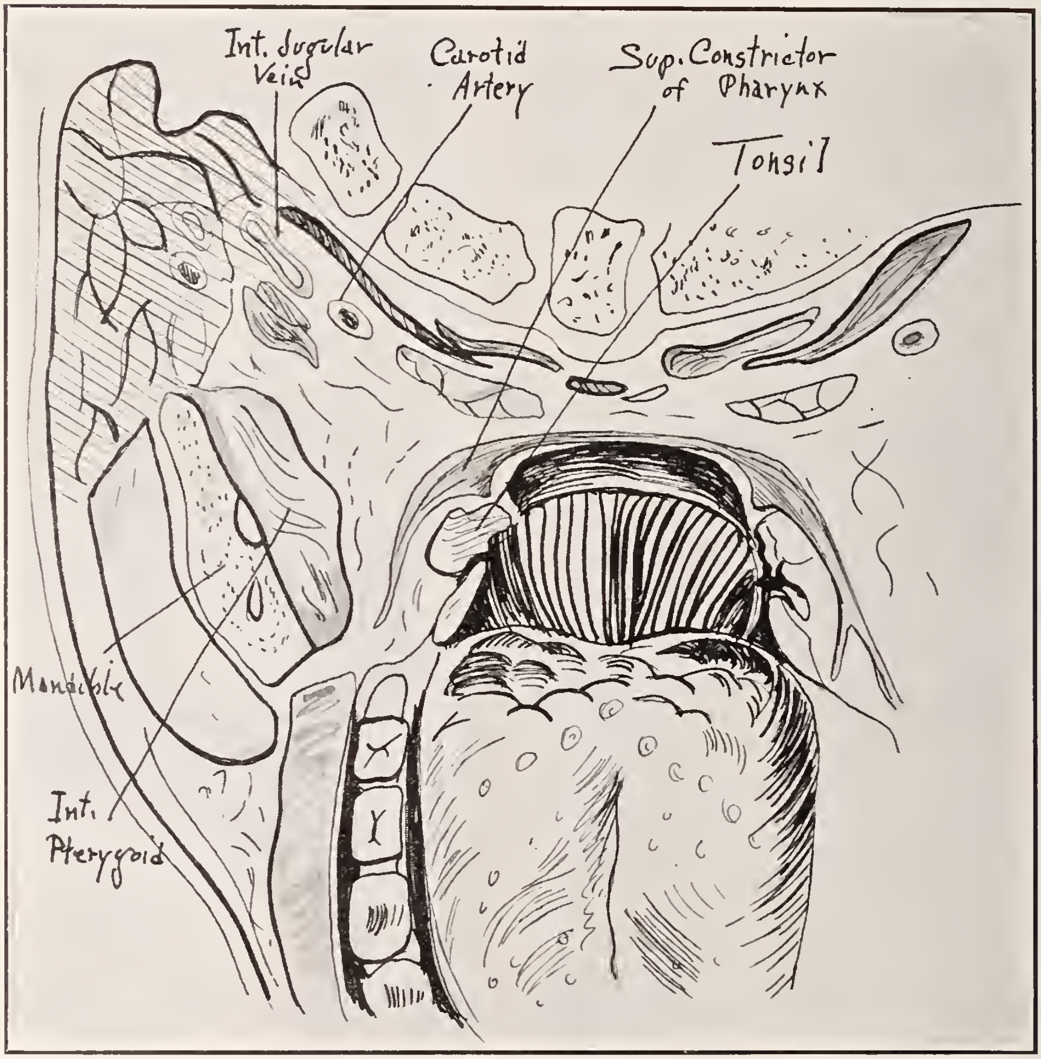
Abscess of the Lingual Tonsil—is not common, but must be kept in mind. There is one-sided dysphagia, trismus, increased salivation and pain. The voice is thick and respiration may be impaired. Mirror examination shows a red, swollen fluctuant lingual tonsil. The treatment, of course, is incision.

Acute Pharyngitis—is an acute exudative inflammation, often seen in tonsillectomized persons. It may follow a severe head-cold, sinusitis, or gastro-intestinal upset. The pharyngeal wall, especially the lateral bands, may be red and swollen. The treatment is largely medical, although local applications of some agent, such as methylene blue, may be effective. Sometimes we see a marked edema of the uvula, which is extremely uncomfortable. If this does not respond to simple astringents, scarification of the uvula usually gives relief.

Vincent's Angina—is an ulcerative inflammation caused by a symbiosis of the bacillus fusiformis and a spirillum. It is usually seen in debilitated persons and has slight general symptoms, but may give rise to pulmonary complications. Examination shows irregular, indolent ulcerations with a detachable soft yellow gray membrane. The edges are abrupt, or sloping. There may be small bleeding points. They may extend from the tonsillar pillars to the gums. It is important to differentiate diphtheria, syphilis, blood dyscrasias and agranulocytosis by making use of cultures, smears and blood counts. Treatment may be local, or intravenous, or both. Any number of chemical agents have been advocated but the arsenicals seem to be most effective.

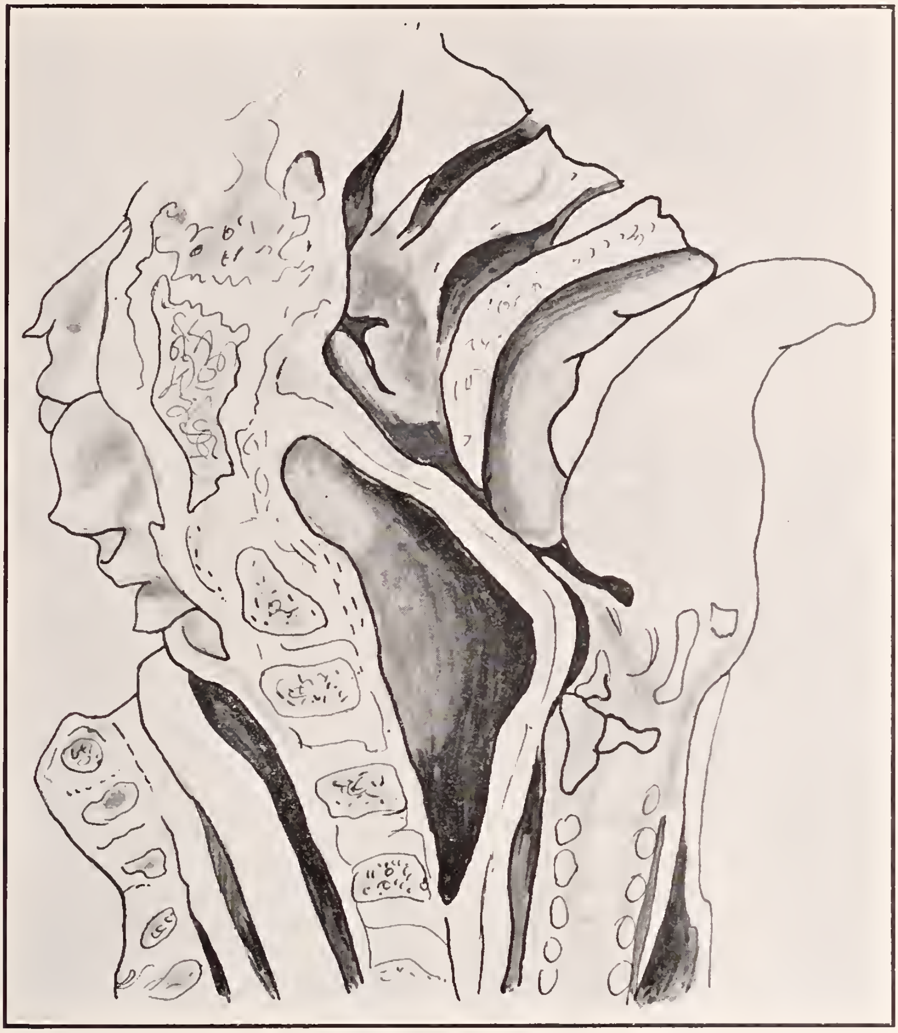
Peritonsillar Abscess — is a local septic infection due to pus above, behind, or external to the tonsil, between it and its muscle bed. It is practically always secondary to tonsillitis. It may give rise to severe complications such as edema of the larynx, lung abscess, from rupture and aspiration; or it may extend through the superior constrictor muscle to the pharyngo-maxillary fossa, with possible involvement of the great vessels of the neck and resulting sepsis. The treatment is incision and evacuation of pus. It should never be considered as a minor infection, but should command prompt and efficient attention.

Retropharyngeal Abscess — is due to pus in the areolar retropharyngeal space between the posterior pharyngeal wall and the cervical vertebræ, anterior to the prevertebral fascia. It is a suppurative lymphadenitis of the glands of Henle found in this space. This condition is most commonly found in infants where, due to the relatively higher position of the larynx, there is greater possibility of respiratory obstruction. The greatest danger in these cases is from rupture and aspiration of pus, or dissection downward to the mediastinum. Great care should be exercised in incising these, to protect the larynx. There is danger in infants in even palpating to make a diagnosis, and this should never be done except in the inverted position, preferably in a hospital with suction available. The treatment is incision and drainage, usually intraorally, but occasionally by the external route.



Cross section of neck at level of second vertebra showing the relation of the tonsil to the pharyngomaxillary fossa.

(from Mosher)



Sagittal section of neck, showing large retropharyngeal abscess in an infant. This illustrates the danger of respiratory obstruction and of aspiration because of relatively high position of larynx.

(from St. Clair Thomson)

Abscess of the Epiglottis—is not common but may occur secondarily to tonsillitis, or other upper tract infection. It may produce distressing dypsnœa. Diagnosis will be made by mirror examination. The treatment is incision and drainage.

Acute Laryngitis—is usually secondary to naso-pharyngeal infections, vocal abuse, or irritation. The symptoms are hoarseness, cough, dysphagia and dysphonia. There is an acute inflammatory reaction of the mucosa of the vocal cords and arytenoids. Later involvement of the intrinsic laryngeal muscles may cause aphonia. All cases of hoarseness should have careful and thorough laryngeal examination. The treatment of acute laryngitis is mainly voice rest. Steam inhalations may be helpful. Local treatment of the inflamed larynx is only mentioned to be condemned.

Laryngeal Edema—is not a disease entity, but always presents a serious situation. It may follow any septic throat or neck infection. The mucous membrane of the larynx is loosely attached in the region of the arytenoids, aryepiglottic folds and ventricular bands, so that infiltration may easily occur in this region. This results in dysphagia, accumulation of mucous and saliva in the pyriform sinuses and possibly spilling over into the glottis, hoarseness, pain and dyspnœa. Cocaine and adrenalin sprays, or inhalations may give some relief, but usually scarification of the edematous tissue is indicated. Tracheotomy should not be delayed if there is impending laryngeal obstruction. The use of sulphanilamide in acute streptococcic throat infections may do a great deal towards preventing this dread condition.

Abscess of the Larynx — may follow as a complication of Tonsillitis or Typhoid Fever. It is a localization in the larynx of infection from above. Pus may burrow downward from such an abscess to the mediastinum. The treatment is internal incision with possibly tracheotomy, and external drainage if perichondritis develops.

Acute Tracheitis—usually occurs with, or following acute laryngitis, and, similarly, may be secondary to infection from above. It may produce distressing symptoms of irritation and cough. Mirror examination shows the tracheal mucosa red and velvety in appearance. Voice rest, inhalations and sometimes the instillation of soothing oils are beneficial.

Acute Laryngo-Tracheo-Bronchitis—often rightly described as fulminating, is a severe infection of the respiratory tract from the larynx to the alveoli, seen occasionally in young children. It is frequently fatal despite most heroic treatment. There is marked laryngeal obstruction which demands tracheotomy but, owing to the extent of the infection, this alone is not sufficient. Rapidly forming crusts may block bronchi and the thick secretion may cause a drowned lung. This presents a real problem for both the laryngologist and the pediatrician. Bronchoscopic aspiration with removal of crusts, postural irrigation and drainage, together with the use of the oxygen tent and maintenance of adequate fluid intake, are necessary therapeutic measures.

Conclusions

Acute infections of the upper respiratory tract may give rise to serious complications, or result in degenerative sequalæ of far-reaching importance. They are frequently the cause of severe thoracic infections, but the upper respiratory tract may, at times, become secondarily involved from the pulmonary area. Treatment should be logical and based upon scientific facts so as not to impede the natural defense mechanism of the body.

Discussion

By R. M. McQuoid, M. D., Bangor, Maine

I am sure that you all feel as I do, that it has been a real privilege to listen to this brief but able presentation of Dr. Hill's on the subject of acute infections of the upper respiratory tract. To cover such an important subject in such a short time is a large assignment, and one that Dr. Hill has succeeded in fulfilling exceedingly well.

The first point that Dr. Hill emphasized is the absolute continuity of all of the structures of the upper respiratory tract. Not only are they all directly continuous one with the other, but the type of mucous membrane lining the various structures is essentially identical. This mucosal lining is in most places ciliated, and contains numerous mucous secreting goblet cells. The beating of the cilia keeps constantly moving the thin film of mucous secreted by the goblet cells. This forms a mechanical barrier to infection. But when this so called first line of defence has been penetrated, there is no other mechanical line of defense to keep any acute infection from spreading from the nasal cavity into paranasal sinuses, or by way of the eustachian tubes into the middle ear and mastoids, or even downward into the pharynx, trachea, or even the pulmonary alveoli. This mechanical barrier removed, defense then falls entirely upon the histeocytic response of the blood.

The second thing impressed upon me is the great importance of preventing acute infection from occurring. This may frequently be done by removing anatomical abnormalities, deviated nasal septum or hypertrophied turbinates causing nasal obstruction, nasal or pharyngeal polypi-removal of enlarged or infected adenoids in children, or chronically infected tonsils where organisms may lie dormant while their host is in good health, only to multiply and spread with increased virulence when said host impairs his health by overwork, dissipation, or exposure. The acute cold is the most common upper respiratory infection. Dr. Hill mentioned cold vaccine. Reports on its efficiency vary greatly, though most articles I have seen seem to agree that while vaccine may not reduce the incidence of colds, it apparently does frequently shorten the duration of the individual cold, and reduces the number of serious complications. It might be of interest to note here that in a very recent article the use of a polyvalent vaccine is recommended for use as a local spray to the nose and throat. (Drs. T. E. Walsh and Geo. Shambaugh, Jr.)

Now what of treatment once an acute infection is found to be present? Dr. Hill has emphasized two very important points here. One is general medical care, including complete bed rest, good fluid intake, proper diet, and good elimination. The second is conservative local treatment. In the case of the acute cold, the ephedrine spray is recommended. This tends to relieve nasal congestion and may serve to prevent spread of the infection to the paranasal sinuses or to the ears. Early paracentesis in acute ititis media may prevent occurrence of mastoiditis later on. The care of any case of acute infection of the upper respiratory tract might be summarized as follows:

General medical care, conservative local treatment, and, where found necessary, conservative but adequate surgical interference.

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*Acute Infection in the Lower Respiratory Tract**

By Donald S. King, M. D., Massachusetts General Hospital, Boston, Massachusetts

Introduction

I notice that in his recent book Kenneth Roberts says that he admires in you, his fellow State-of-Mainers, your "suspicion of untried and unsound measures" but also your "eagerness for education." I take from this a warning and a hope: a warning that I can hardly expect you to believe that we are approaching a millenium in the treatment of acute infections of the lower respiratory tract but the hope that you are interested in what is "Trending into Maine" and other states and that if important changes are on the way you wish to be "ready when the great day comes."

The trend in the management of acute pulmonary infection is toward more careful bacteriologic study of each case, and the use whenever possible of a serum or drug specific for the particular organism which is found. In the biologic field, there are being developed sera against some twenty-seven higher types of pneumococcus. This serum came originally from the horse, and now comes also from the rabbit. These new sera have greater concentration of the specific anti-bodies and less of the non-specific chill-producing factor. On the chemical side is sulfanilamide (prontylin) and its use in hemolytic streptococcus infection of the lung, as elsewhere in the body, its use in pneumococcus infection being on the whole disappointing.

It is much too early to draw real conclusions as to the effects of most of these treatments, and I shall make no attempt to do so. At this particular moment in medical history, it is more important to survey the field of acute pulmonary infection, and attempt to divide the cases into large clinical groups, stating what is known of the bacteriology of each and what treatment seems at the present time reasonable to try.

As a rule the type of pneumococcus which gets into the lung determines whether there will be lobar or bronchopneumonia. It is now held to be more important to determine the type of pneumococcus than to speculate as to the distribution of the pulmonary consolidation. Acute upper respiratory infection may precede either form but in lobar pneumonia as distinguished from bronchopneumonia the specific pneumococci, with the exception of Type III, are not commonly found in the respiratory tract of healthy individuals. They are fresh invaders which give a typical disease of an epidemic nature, more common in cities than in the country, in winter than in summer, and in the male than the female. The classical symptoms are chill, pleurisy, rusty sputum and a pulse to respiration ratio of 3 to 1 or 2 to 1 instead of the normal 4 to 1.

Now as to types of pneumococcus which give this classical picture. You will remember that in the old classification of pneumococci there were the "fixed types" I, II, and III, and then group IV which included all other pneumococci. In the new classification,

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* Read before the 1938 Annual Session of the Maine Medical Association, June 27, 1938.

Type I remains unchanged; Type II is now split into Types II, V, and VI; Type III is split into III and VIII; Types IV and VII are new, and give typical lobar pneumonia. The relative percentage of lobar pneumonia caused by each type varies in different localities and in the same locality in different years. But roughly, 80% of all adult lobar pneumococcus pneumonia can now be classified as follows:

Type	
I	25%
III	15%
II	10%
V	8%
VII	8%
VIII	8%
IV	5%

This means that lobar pneumonia is caused by Types I through VIII with Type VI being unimportant.

Bronchopneumonia

Bronchopneumonia differs from lobar pneumonia in that it is often secondary to infection elsewhere in the lung and is caused by organisms commonly present in the upper respiratory tract. The onset of bronchopneumonia is usually without chill and pleurisy, and there is less apt to be bloody or rusty sputum. The symptoms may, however, be severe although the signs at first are more those of localized bronchitis than of definite consolidation.

The etiologic agent may be pneumococcus, or streptococcus, or some other organism. Where a pneumococcus is responsible Finland (ref.[1]) reports that the types occur in the following order of frequency: III, its sub-type VIII, X, XX, VII, XVIII, etc. Laboratories are working on the development of sera for these "higher" types. The future holds the answer as to their value.

"Streptococcus Pneumonia"

There are small epidemics of what has been called streptococcus pneumonia. These cases resemble the epidemic influenza of 1918, and it is highly probable that the original infection is a virus infection and that this is followed by invasion with hemolytic streptococci. There is marked prostration, severe cough, dyspnea, cyanosis, picket-fence temperature, and a low white count. Many cases develop a sudden fatal hemolytic streptococcus empyema. As the empyema develops, the white count rises rapidly.

The following is a typical chart of a recovered case. The next chart is of a fatal case which did well at first, but then had a sudden rise in temperature and white count, and died within twenty-four hours from streptococcus empyema. The early chest X-ray showed a miliary type of bronchopneumonia in the right lung which appeared innocent enough, but the following day empyema had developed on the left side, and death occurred. The next slide gives a more typical X-ray picture.

We cannot say at the present time what sulfanilamide does in this type of case. Since this drug has been available no epidemic has occurred. We have, however, had a few cases where hemolytic streptococcus and not pneumococcus seemed to be the primary agent. These cases have done moderately well on sulfanilamide. There have also been cases where the hemolytic streptococcus not present at first appeared as a late invader. Some of these were treated successfully by sulfanilamide.

There is still much discussion as to the way in which this drug works, and much investigation remains to be done. It is apparently not directly bacteriocidal in its effect, but is bacteriostatic in that it holds in check the growth of the organisms in the body and permits the natural immunity factors to get in their work. Many hold that sulfanilamide is of little use even in large doses unless the patient is producing his own antibody, but that with natural or artificial antibody present, small doses of the drug give excellent results. Perhaps the eventual answer in pneumococcus pneumonia is serum plus sulfanilamide. But in the meantime, I believe that in acute pulmonary infection sulfanilamide should be used only in proved cases of severe hemolytic streptococcus infection.

Pneumonitis

We turn now from the end of the scale in which are the severe and often fatal pneumonias to the other end where there are cases with few symptoms, and the diagnosis of pneumonia is established only with the help of the X-ray. The cases are often called "grippe" or "influenza" or "acute pneumo-

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Ref.[1] *Ann. Int. Med.* 10:1531, April, 1937.

nitis" although they are really mild pneumonias. The temperature is picket-fence in type. Lung signs are few. The white count is normal or slightly elevated, and the chest X-ray usually shows an area of even density spreading out from the hilum and not the scattered mottled areas typical of bronchopneumonia. The next slide is characteristic. The disease is most often epidemic in schools, colleges, or army posts. Attempts have been made to find the etiological organisms, but sputum is difficult to obtain and few organisms are found. Cultures usually fail to show pneumococci or hemolytic steptococci, but do show staphylococcus, streptococcus 'viridans, or influenza bacilli. Serum and sulfanilamide obviously are not indicated in these cases.

Personally, I prefer to call these cases mild "bronchopneumonias" and to confine the term "pneumonitis," as the pathologists do, to a chronic type of interstitial, not alveolar, infection often resulting in organization and fibrosis. In acute pulmonary atelectasis or collapse, however, there is often an associated infection which is perhaps better described as pneumonitis than pneumonia since alveolar exudate is not present.

Pneumonia in Elderly Patients

Besides the types of pneumonia described with moderate symptoms and few physical signs, there are cases with few symptoms and marked physical signs. This type sometimes occurs in elderly patients and may at times be rightly called hypostatic pneumonia. Abortive types of pneumonia with typical physical signs may, however, be found at any age. How often we have made the remark when the temperature has dropped by crisis on the second or third day that if this patient had been given specific treatment we would have credited the serum with the rapid recovery!

Acute Bronchitis

I am impressed with how seldom in city and hospital practice we see textbook cases of acute bronchitis that are obviously sick, and have bilateral moist basal rales but with no X-ray evidence of pneumonia. Such cases undoubtedly occur, but many cases so diagnosed in the past would undoubtedly have shown X-ray evidence of pneumonia. We see, of course, cases of acute bronchitis with a universal distribution of musical rales. I wish to stress one point in connection with acute bronchial infection, namely, that such infection may cause all degrees of bronchial obstruction with resultant changes in the lung. We are so apt these days to think of bronchial obstruction as due to chronic processes, particularly cancer, that it is important to realize that slight, or even complete obstruction, of the bronchi may occur during acute infections. In children, particularly, atelectasis occurs in the course of acute pneumonia.

So much, then, for the acute lower respiratory infections and present trends in their treatment. I should like to spend the rest of my time on differential diagnosis with short case presentations.

Tuberculosis

Most textbooks state emphatically that tuberculous pneumonia does not come out of a clear sky, that it has a low white count, and is apical and not basal—good rules but like all medical rules, breakable.

A man of thirty-two entered the hospital with no history of exposure to tuberculosis and no respiratory symptoms until the present illness. Eighteen days before he had had coryza and night sweats and later dry cough and chilly sensations followed by brownish expectoration. Admission temperature 104. Pulse 120. Respirations 45. White count 34,000, later 60,000 with 97% polymorphonuclears. The X-ray shadow was consistent with lobar pneumonia. The expected crisis did not, however, occur, and the patient died three weeks after admission. A few days before death tubercle bacilli were found in the sputum. Autopsy showed tuberculous pneumonia and no other infection.

The next case was a girl of fourteen with no family history of tuberculosis, and no known exposure. Two weeks before this film was taken there was a "cold" with left pleural pain. A slight wheeze could be heard below the left clavicle. The sputum was purulent. In spite of the acute onset the attending physician suspected tuberculosis because of the persisting upper lobe process, and the sputum did show tubercle bacilli. The circular area consistent with cavity makes the probable diagnosis in this X-ray film. Without the cavity the X-ray could very well be that of non-tuberculous bronchopneumonia.

The next case had suspicious loss of weight and fatigue before the onset of an acute respiratory infection. There were rales at the right apex and the X-ray film showed a process consistent either with tuberculous or non-tuberculous bronchopneumonia. There was no evidence of cavity. A film taken a week later showed almost complete clearing. The case is therefore non-tuberculous pneumonia. We have recently seen a similar case started at once on a three-year course of artificial pneumothorax treatment in the belief that it was tuberculous.

The next case was originally diagnosed as non-tuberculous bronchopneumonia because the process was located at the base of the lung. Serial X-rays, however, showed an increasing process and in a few months there was a positive sputum and typical tuberculous cavitation. Particularly in the adolescent, basal processes may be tuberculous, although as a rule they are non-tuberculous.

Before leaving the subject of tuberculosis, I would call your attention again to the problem of bronchial obstruction. When tubercle bacilli invade the lung tissue, they often invade also the mucous membranes in the larger bronchi. Bronchoscopic examination shows the frequency of this complication. Such infection may give rise to every degree of bronchial obstruction from a small area of localized wheezing to atelectasis of an entire lung. In the following case, the first X-ray showed minimal tuberculosis in the parenchymal lung tissue. In a month tuberculous granulation tissue had completely obstructed the right upper lobe bronchus with resulting collapse of the upper lobe against the mediastinum as a fan might close.

Pulmonary Infarction

A typical case of pulmonary infarction presents no difficulties in diagnosis. Following operation phlebitis develops in an extremity. From this comes a pulmonary embolus with resulting infarct giving sharp pleural pain, frankly bloody sputum, and fever. Often the phlebitis is assumed to be in the pelvis although it cannot be proved. But there are many less typical cases.

We have recently seen a patient of twenty-five, who two weeks earlier had a cold with a temperature of 104, marked sweats, and a white count of 6,500 with 69% polymorphonuclears. Two days before he had had for the first time very severe left pleural pain and large pulmonary hemorhages. There was cyanosis, but little cough. His doctor had made a tentative diagnosis of pulmonary tuberculosis. Later there was severe right-sided chest pain and more hemoptysis, and it was not until after this that a more careful history revealed a possible source for pulmonary emboli. Three months before, the patient had begun injection treatments for hemorrhoids, and two weeks before the onset of the present illness he had had the last injection. We did not prove that the hemorrhoid was the source of pulmonary emboli, but this seems highly probable. Recovery was complete.

Besides operative procedures which may be masked as they were in this case, phlebitis may develop without operation, and be difficult to localize. Sometimes very careful examination of the popliteal region will disclose the source. One patient, famous in hospital history, had only a sprained ankle which was responsible for a phlebitis from which came showers of eventually fatal pulmonary emboli. Of course, any heart condition is a potential source. We have had two cases of pleurisy with hemoptysis and X-ray pictures consistent with infarct where the only explanation lay in a mild sore throat. At post-mortem multiple infarcts are often found without the typical story of pain or hemoptysis.

The typical X-ray picture of infarct is a triangular shadow, but it is very difficult to find shadows which are really triangular in form. The following slide shows an infarct in the right middle lobe, the embolus having come from the obviously large heart. This case was proved at autopsy. The next slide shows less obvious triangular shadows that proved to be septic infarcts. Another slide shows multiple emboli, plus bronchopneumonia, plus pulmonary sclerosis. In such cases anti-morten diagnosis is difficult.

Pleurisy With and Without Effusion

Pulmonary infarcts are frequently followed by pleural effusion. So in the differential diagnosis of pleurisy with and without effusion, as well as with and without hemoptysis, we must think of the possibility of an underlying infarct. With infarcts, the effusion is frequently bloody.

Post-Operative Pulmonary Complications

Post-operative pulmonary complications which occur in the first four post-operative days with fever, cough, and greenish sputum are almost always atelectasis and not pneumonia. Out of more than 400 proved pulmonary complications, only 30 were true bronchopneumonias. This point is still not sufficiently appreciated. A man of forty-five was operated upon for hernia and on the third post-operative day developed fever and cough and small amounts of purulent sputum. The sputum contained Type III pneumococci. At the time sulfanilamide was coming into use and success had been reported in Type III pneumococcus cases. I was asked whether sulfanilamide should be given. The patient presented the typical post-operative picture. He had been kept quiet because when he moved it hurt the wound. At the right base posteriorly, there was marked dullness with absent breath sounds. The left border of the heart and the trachea were slightly displaced toward the right side. A chest X-ray showed a typical shadow with a triangular area of dullness representing the collapsed lower lobe, and displacement of the mediastinum toward the affected side. Type III pneumococcus is often found in these collapse cases. The obvious treatment was not sulfanilamide but bronchial drainage, and the foot of the bed was elevated about six inches and the patient placed on his left side. After moderate percussion of the right base, he began to cough and raise large amounts of the typical pea-soup sputum. After the "bronchial plug" had been expelled, examination showed marked bronchial breathing over the right base, which is consistent with collapse with the bronchus now open. With a few hours his temperature had dropped to normal and the lung had reopened.

In post-operative cases, then, it is important, when the diagnosis of pneumonia is raised, to consider post-operative atelectasis, and pulmonary infarction.

Miscellaneous

Pulmonary abscess is usually a post-operative complication, particularly after tonsillectomy and other operations on the upper respiratory tract. There are, however, a number of cases in which the abscess develops insidiously. The fever and cough in these cases make one suspicious of an atypical pneumonic infection. It is not until the patient begins to raise foul sputum and the X-ray shows a cavity with fluid level that a definite diagnosis is made.

In recent years many articles have appeared describing infections of the lung accompanying rheumatic fever. There is some doubt as to whether there is such a condition as true "rheumatic pneumonia" with alveolar infection. There is, however, a general acceptance of the term "rheumatic pleurisy" and most observers believe there is a "rheumatic arteritis" which is associated with pulmonary congestion and atelectasis, and probably interstitial pneumonitis.

Cases of bronchiectasis and chronic bronchitis with asthma have acute exacerbations of pneumonia, and in any acute pulmonary infection we must search for a possible chronic background. In many cases these pneumonias become organized, giving pulmonary fibrosis. Acute infection may also come as a result of chronic bronchial obstruction by cancer or other process.

Summary

Present treatment of acute pulmonary disease requires bacteriologic study. In lobar pneumonia serum has proved its worth. In pneumococcus bronchopneumonia serum offers hope. In hemolytic streptococcus pneumonia sulfanilamide offers hope. In "acute pneumonitis" no special treatment is necessary. In acute bronchitis there is nothing new to offer.

Before making a diagnosis of *acute* pulmonary infection, one must rule out tuberculosis of the lobar type, and of the bronchopneumonic type at the base as well as at the apex, and of the bronchi.

A differential diagnosis must also include typical and atypical pulmonary infarct, post-operative atelectasis, pulmonary abscess, rheumatic pulmonary disease, and acute infection grafted on chronic bronchial infection or obstruction.

Discussion

By Charles W. Steele, M. D., Auburn, Maine

Doctor King has covered this topic in such a thorough manner that there is little, if anything, left for me to add in the way of a new presentation. Perhaps my time can best be spent, therefore, in emphasizing the importance of some of the points which he has already made, and by calling to your attention again some of the non-tubercular conditions which are often diagnosed in general practice as tuberculosis.

Our experience would seem to indicate that patients with chronic bronchitis, and bronchiectasis and patients with bronchogenic tumors are the ones most commonly misdiagnosed, and sent to the tuberculosis sanitorium. Certain important diagnostic points that Doctor King has made about these three conditions seem worth re-stating in an effort to fix them thoroughly in mind.

Chronic bronchitis is often not a primary lung condition, but is secondary to inhalation of dust, pneumoconiosis, chronic pulmonary congestion due to mitral stenosis or cardio-vascular disease, emphysema, atelectasis, posterior nasal drip, allergy of the respiratory tract or partial bronchial obstruction.

In any case of suspected chronic bronchitis, some other primary disease should always be sought. The symptoms of cough and expectoration are invariably worse during the winter months, and tend to clear up or disappear in the warm weather and recur again with the first head cold of the following winter. Physical signs may be entirely absent but when present, are mainly osculatory and consist most often of medium or coarse, bubbling rales at the bases, while the breath sounds are diminished in intensity and the expiratory phase prolonged. The sputum may be scanty or it may be more abundant and mucopurulent in character. X-ray plates may be negative or show some thickening along the course of the lower lobe bronchi.

Bronchiectasis is a fairly common and serious pulmonary disease. As Doctor King has pointed out, it may be unilateral or bilateral.

The non-tubercular form more often involves the middle or lower lobe bronchi, but it may involve the bronchial tree in an entire lung. The history is likely to bring out that the symptoms began after whooping cough in childhood or after an attack of pneumonia or influenza. The symptoms are those of paroxysm of chronic cough, productive of much mucopurulent and sometimes fetid or bloody sputum, which separates into three layers, when allowed to stand. Physical signs consist of medium and coarse, bubbling rales, tympanic percussion note and increased vocal fremitus over the involved bronchi, unless the bronchial dilation be filled with secretion, when there is dullness and diminished resonance.

The X-rays, in a well-marked case, are unmistakable for in no other condition does one get stubbing and blunting of the bronchial tubes. In less marked or doubtful cases, X-rays taken after the injection or lipiodal can usually be relied upon to bring out the early bronchial changes. It is important to recognize this condition early, for it lends itself well to surgical cure by lobectomy, if confined to one lobe or to pneumonectomy if confined to one lung. When neglected or undiagnosed, it usually becomes eventually bilateral and hence uncurable.

Benign adenomata of the bronchus and carcinoma of the bronchus deserve special mention. In the last few years, it has become apparent that these two conditions are more common than previously realized. Biopsy is the only sure way to differentiate between the two. Both conditions begin insidiously. Cough is, perhaps, the most common symptom. The development of a respiratory wheeze in a previously healthy person should always suggest the possible presence of bronchogenic tumor. Sputum may be bloody at times, and there may be more or less chest pain and weight loss. The physical signs usually depend entirely on the amount of bronchial obstruction with its resultant atelectasis and pneumonitis. X-rays are indispensable, and the diagnosis is confirmed by a bronchoscope.

It is urged that you keep bronchogenic tumor constantly in mind; for now that such extraordinary strides have been made in the field of lung surgery, many of these cases can be cured by operative removal providing you, as practitioners, will make the diagnosis early before metastasis has occurred.

Less frequently, pneumoconiosis without tuberculosis, lung abscesses, obscure upper lobe pneumonia or pneumonia with slow resolution and pneumonitis are mistaken for tuberculosis; but time does not warrant any further discussion of these less common conditions.

In conclusion, let me point out that the symptoms of cough, expectoration and bloody sputum, alone, do not prove the diagnosis of tuberculosis. All of these symptoms may appear in any one of several other important non-tubercular conditions. It is a very simple matter to have the sputum examined for acid fast bacilli and for other organisms. Arrange to have the chest X-rayed. It may give you valuable information. And, lastly, take time to examine your patient and to get his history. Much valuable time, and perhaps even life, will be saved, if you will only do these simple things while you bear in mind some of these other important lung diseases which Doctor King has so ably described this afternoon here. I thank you.

President Wakefield (Bar Harbor): Thank you, Doctor. This paper is now open for general discussion, Gentlemen.

Doctor Pratt (Farmington): I don't know how to say this, but I do think that one of the most important things we should remember, that have been said here this afternoon, is that the common cold is the most frequent disease, and I will put sore throat with that, that we have and probably the most neglected. When we remember that practically one hundred per cent of the bronchial pneumonias follow the common cold, and that seventy-five per cent of the lobar penumonias are preceded by a common cold, then I will say that I think practically all of these complications could be prevented, if these patients with the common cold were put to bed for three or four days and treated properly.

Doctor Piper (Waterville): I should like to ask Doctor King about atelectasis in pneumonia, and how we distinguish it from post-operative complications. I would like to ask him the status of this, as talked about by Jackson and Sussman.

President Wakefield: Are there any other questions? If not, perhaps Doctor King would like to answer some of these questions now, and close this discussion.

Doctor King: In regard to atelectasis in pneumonia, I think it occurs more often in children than in adults. I shall be interested to see whether the next speaker mentions pneumonia in children. I think it does definitely happen in children. It does happen in adults during convalescence. I have seen it a number of times. Of course, you get bronchial obstruction quite often in the various phases of pneumonia, without it being there long enough, but I think it does happen, particularly in children. I don't think lobar pneumonia, post-operatively, happens very often. The cases are mostly bronchial cases.

The differential diagnosis depends largely on displacement of the mediastinum toward the affected side. Quite often, it is difficult to say, because you have a bilateral process and the mediastinum hasn't shifted. I think, as a rule, these are the post-operative complications of atelectasis.

Of course, there is infection with the atelectasis; pneumonitis, I think, does not enter into those cases.

I think that we are at an interesting period in these acute infections, especially with the serum being developed so rapidly. It is just a question of how far we can go and we must realize that it will take time to decide these questions. They tell a story about a Boston doctor, who was used to moving pretty fast. He had to take a half a day off one time to go to a funeral. His car was right behind the hearse. He remembered for the first half hour that he was to drive slowly, but before he got to the cemetery, his mind got taken up with something else, and he found himself blowing his horn and trying to get by the hearse.

So, also, we have got to be careful about how we proceed. I thank you.

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Ocular Headaches—Some of Their Common Causes

By Lloyd H. Berrie, M. D., Houlton, Maine

Headaches due to ocular derangement are common in the everyday practice of the family physician. The more usual causes include imbalance of the external eye muscles; astigmatism; the ageing lens; near-sightedness; far-sightedness; and muscle spasm within the eye. A fair knowledge of the mechanisms of these disturbances may be helpful to the general practitioner in making his differential diagnosis and in suggesting the need of placing the patient in the hands of a competent oculist.

The pain that arises from eyestrain may be contiguous to the eyes or may be referred to some remote part. The back of the neck is a common location for pain arising from muscle imbalance. Usually headache arises soon after the eyes are used, but it is important to note that it may be delayed for hours. In differentiating the headache of eyestrain from other types it is always well to remember that ocular neuroses is a common ailment; especially in women. The eyes by virtue of their origin from, and their intimate connection with the brain and central nervous system, are particularly prone to cause symptoms when derangement of their functions occurs.

Associated with pain and headache is vertigo, a symptom often present in high astigmatic errors and muscle imbalance. Gastro-intestinal symptoms are not uncommonly allied. The presence of vertigo, however, should always call for examination of the blood pressure, urine and retinal vessels for evidence of pathology, and of the blood serology and cell count. Recurring nocturnal headache should suggest syphilis, and pain arising in the morning and subsiding gradually during the day may be due to sinus infection. There is generally some association with the use of the eyes and headache of ocular origin.

Probably the least understood cause of ocular headache among the profession at large is that arising from imbalance of the external eye muscles. The motion of the eyes is controlled by twelve muscles; six to each eye. An easy way to understand the basic nature of muscle balance is to look at an object with each eye alternately, realizing that one is seeing the same object with both the right and the left eye. Why then when both eyes are used together is there not two images? This is because certain brain centers cause proper impulses to be sent out to the external eye muscles in such balanced degrees that they are able to "line" the visual axis of each eye on the image. The result is that the two images are fused into one. One might say that the two eyes are synchronized on the image.

Frequently such synchronization is attained only under stress due to the fact that in many individuals some muscle or muscles are continually overacting. If, for example, one superior rectus muscle is overacting and tending to draw the eye upward, this can be prevented only by a compensating overaction of the inferior rectus. Such abnormal tension causes easy fatigue when the eyes are used, but as long as the compensating muscle can balance the bad acting muscle's pull, the eyes will appear perfectly straight. The vertical imbalances are particularly prone to cause severe symptoms where there are but small errors.

Abnormalities of convergence and divergence are also frequently present. When one's gaze shifts from a far point to an object close to the face the two eyes must turn in, or converge, in order for the near object to be seen clearly. The internal recti muscles must act together to pull the eyes in, while the lateral recti muscles are inhibited to an equal degree. If now the eyes are again directed to a far object they normally turn out, or diverge, under the action of the lateral recti muscles, with the internal recti actions inhibited. Many people who have ocular headaches have partial failure of convergence or divergence, or it may be over-convergence or over-divergence due to over-action of some muscle or muscles. These individuals also have straight eyes because of the ability of the muscle opposite to the primary offender to compensate adequately. The competent oculist can easily detect such imbalances by breaking up the fusion sense of the brain sufficiently to enable measuring the error. Such cases are treated according to the type of imbalance, some requiring only proper eye exercises, and others being relieved by wearing properly fitting lenses that may contain prisms.

There are three important clues in the history of a patient suffering from muscle imbalance, one or all of which may be present. Low occipital or "neck" headache; dizziness or headache that comes on while riding in a car or watching moving objects; and a story of having had several pairs of new glasses within a short span of time from several incompetent "glass fitters."

The pain from astigmatic eyes is often located in the brow, temple or back of the eyeball. In the usual form of astigmatism rays of light that enter the eye in one meridian come to a focus in front of or back of the rays of light that enter in the other meridian. The common type of astigmatism is where the involved meridians are either horizontal or vertical to the erect body. Large errors will cause untold discomfort. When the error is oblique to the horizontal or vertical plane exceptionally severe symptoms are the rule, including dizziness and gastro-intestinal upsets.

At about the age of forty the lens of the eye begins to gradually lose its elasticity and the range of accommodation is diminished. This means that there is an increased "load" placed on the eye when it is called on to do near work. With advancing age and loss of lens elasticity the muscle that acts on the lens, changing its shape and power, becomes less and less efficient for near work and there results a blurring of near images. Unless suitable lenses are worn before the eyes shortly after the onset of this condition (and they seldom are), ocular distress in the form of headaches and sore eyes will be present. The age of the patient and a history of being unable to read during the latter years gives the clue. Of course in such a progressive changing condition new lenses must be added from time to time in order to fully compensate for the loss of accommodation.

Near-sightedness, or myopia, causes ocular headaches. In such eyes rays of light entering the eyes from a distance come to a point in front of the retina. Compensating mechanisms within the eye are unable to bring vision up to normal and the rays cannot be focused on the retina. Slight amounts of myopia sufficient to cause headaches may go undetected for long periods. Because the muscle which acts on the lens of the eye sometimes becomes spastic a pseudo-myopia is encountered. It is for this reason that near-sighted people should invariably be refracted with "drops" in the eyes so that a temporary paralysis of the lens muscle (ciliary muscle) is created.

With the far-sighted, or hyperopic eye, compensating mechanisms within the eye can take care of small errors and the patient sees clearly, especially at a distance. Ocular distress, however, is bound to occur sooner or later because vision is attained by virtue of an overworked compensating mechanism.

A small but important percentage of patients who may complain of headache, sensitivity to light, or discomfort when watching objects in motion are suffering from aniseikonia. Here there is a difference in the size of the image in the two eyes. About 70% of such patients can be relieved by wearing proper correcting lenses.

Chronic low grade conjunctivitis is very, very common especially with city dwellers, in dusty communities and among the aged. It is also nearly always present in a slight degree when there is some physiological derangement in the ocular apparatus. If on turning down the lower lid the conjunctiva is seen to be definitely red and congested such a sign, along with the history, may be additional evidence pointing to the ocular apparatus as the cause of headache.

Medico-Legal Conference in Boston

A most important and instructive two days' work in medico-legal problems is to be held in Boston, program below, October 4th and 5th. All medical examiners in Maine, together with the county attorneys, are cordially invited to attend. They will be most welcome guests. It will materially aid the committee in charge if those planning to attend will make advance registrations so that the approximate number who will attend can be cared for. Kindly advise Dr. William Henry Watters, 270 Commonwealth Avenue, the day or days you plan to be present.

Program

Medico-Legal Conference to be held October 4th and 5th at the Mallory Institute of the Boston City Hospital

OCTOBER 4TH		OCTOBER 5TH	
A. M.	P. M.	A. M.	P. M.
9.00-9.30 Medico-Legal Law, U. S.	2.00-2.30 Identification, Finger Prints	9.00-10.00 Brain Injuries Demonstration and Discussion of Cases	2.00-2.30 Postmortem Changes, Time of Death, etc.
9.30-10.00 Legal Medicine, Europe	2.30-3.00 Identification Moulage, etc.		2.30-3.00 Medical Examiners, Routine and Records
10.00-10.30 The Doctor in Court	3.00-3.30 Ballistics	10.00-10.30 The Doctor and Industrial Accidents	3.00-3.30 Industrial Poison Demonstrations
10.30-11.00 The Doctors and the Police	3.30-4.00 Photography, X-ray, Ultra Violet Light, etc., in Identification	10.30-11.00 The Doctor and the Undertaker	3.30-4.00 Blood in Drowning, Alcoholism and CO Poison
11.00-12.00 Postmortem Demonstrations	6.30-9.00 Dinner (Informal), Addresses	11.00-12.00 Postmortem Demonstrations	

Editorial

Continuing Professional Education

If there is to be continued a commensurate advancement by the practitioner of medicine it must be obvious that to the rank and file of the profession access to the newer methods and practices must be available. Education must continue else individually and collectively the quality of practice deteriorate and experience has shown that a well-planned graduate program contributes a great deal in the developing of better practitioners. Many states are more fortunate than we in Maine since some have undergraduate schools of medicine that have assumed a great part of the burden in supplying instruction to those already settled in practice. The committee on graduate education in this state wishes that graduate instruction with us could be assumed in part under academic guidance, but if we are to continue the education of the general practitioner, who even today with our multiplicity of certifying boards and specialists is the backbone of the profession, it must be realized that the interests of these men and women is and should be in clinical subjects and their daily application.

It is felt by the committee, to a great extent, that the county societies should indicate those subjects that they wish studied and the particular advances in medicine they would have explained. There is a decided gap between the many advances of medicine and their daily application by the physician and the sole object of this endeavor is to lessen the time to the doctor who would continually improve his skill as a practitioner. Courses or talks, on the basis of practical instruction, offer a most excellent plan of increasing the efficiency of those not in a position to benefit by close affiliation with our larger hospitals and clinics in their daily work and every effort will be made by the committee to furnish as speakers those in the forefront of medical science and progress.

It is realized that the more that graduate instruction can be made available to every physician without cost, or at a minimum one, without leaving home and practice for long periods, the more can be accomplished. The difficulties and perplexities of extramural education are many, yet there are few, if any, county societies that cannot meet the challenge to provide much for themselves in real worthwhile efforts along these lines. A meeting is being planned for the 18th of September, at which the committee on graduate education hopes to meet every secretary of every county society. The editorial board of the JOURNAL, the president of the Maine Medical Association and the secretary will be present and it is hoped by a free exchange of ideas and opinions a most excellent start can be made in the outline of a program for the year to come.

Interesting and important as research in medicine and surgery may be, its value resides in its applicability to the demands of daily practice. Information should and must come from men divorced of any commercial tinge. New drugs, newer methods of surgical technique all must stand the acid test of clinical trial by clinicians unbiased in every way. If these procedures and newer drugs have merit and worth it is the duty of those more fortunately situated than others to present the facts and demonstrate as far as possible the advances in technical procedures to the entire membership. Conferences and round table discussions between a clinical teacher and a group of physicians, many times with clinical material available, can far better elucidate obscure points and bring to the practitioner a better appreciation and conception between the new and the old, the theoretical and the practical, than is at all remotely possible in the didactic type of instruction.

As has been stated in the JOURNAL of the Maine Medical Association, courses in the Bingham and Commonwealth Funds are available to physicians who are qualified and full information can be obtained by request to the Secretary of the Association or Dr. Frederick T. Hill at Waterville. Those desiring instruction in special work at their own expense will be aided by the committee in every way possible at its command.

The President's Page

To the Members of the Maine Medical Association:

In beginning my page for this issue, I wish to express my appreciation to Piscataquis County for the hospitality shown to me on July 21st at Squaw Mountain Inn. The weather, attendance and program were all that one could desire and it was indeed a pleasure to meet, once again, Doctor Ralph H. Marsh of Guilford, who was President of our State Association twenty years ago.

Now for a few pertinent remarks: Every member of our Association knows that a nation-wide survey by the Federal Government has been undertaken to prove that the citizens as a whole are inadequately cared for by the Medical Profession, and that Socialized Medicine is the only solution for this problem.

Unfortunately this idea has been expressed by several of our Medical men, who, if it were not for their antagonistic and socialistic ideas, would be regarded as outstanding men in their profession. This fact alone is a matter of no little concern.

My purpose for bringing up this question in this issue of the JOURNAL is due to the fact that the American Medical Association in return is recommending that each County Society in every State in the Union also carry out a survey, a program of which is prepared by the Bureau of Medical Economics of the American Medical Association. The purpose of this survey is to give us the true facts regarding the standard of medical care available to the public.

From reports, I have been led to believe that these pamphlets and questionnaires are still in the office of the President or Secretary of several County Societies in the State, and that no attempt has been made to appoint committees to carry out the instructions of the American Medical Association.

Therefore, it is because of these unfavorable reports that I am appealing to every President and Secretary of the County Societies to refer to the two pamphlets published by the Bureau of Medical Economics of the American Medical Association and proceed at once to carry out the program as outlined. And if additional pamphlets or questionnaires are required they may be procured from the office of the Maine Medical Association, 22 Arsenal Street, Portland, Maine.

This will at least help to solve one of the many problems which are destined to face us in the near future.

WILLARD H. BUNKER, M. D.

County News and Notes

Cumberland

Sixty members of the Cumberland and York County Medical Societies attended a joint outing at Long Island, Wednesday, August 24th. Entertainment included a clam bake at Cushing's and a baseball game between the two societies.

E. A. Greco, M. D., chairman of the committee on arrangements, was assisted by Thomas A. Foster, M. D., and E. H. Drake, M. D.

Henry W. Lamb, M. D., of Portland, was married on August 24th to *Miss Helen B. Lord.*

Thomas A. Martin, M. D., who has recently completed a post-graduate course at St. Luke's Hospital, Kansas City, Missouri, has returned to Portland. Office, 131 State Street.

Hancock

A meeting of the Hancock County Medical Society was held at The Shore Club, Bar Harbor, Maine, Wednesday, July 27th, at 8.30 P. M.

Fred Geier, M. D., Washington, D. C., the speaker of the evening, spoke on "Criteria for early diagnosis of cancer of the stomach, with clinical analysis of the value of flexible tube gastroscopy." Discussion by W. E. Clark, M. D., Washington, D. C., and David Reisman, M. D., Philadelphia, Pa.

P. A. ALLEN, M. D., *Secretary.*

York

York County Physician Honored

Frederick A. Bragdon, M. D., honorary member of the York County Medical Society, who received the Association's Fifty-year Gold Medal at the 1933 annual session held at Poland Springs, was honor guest at Acton Fair Grounds on "Doc" Bragdon Day, August 25th.

The Doctor was presented with a gold horse mounted on a marble slab and a substantial sum of money from his many patients and friends. He was brought the greetings of the whole State by Governor Lewis O. Barrows. The presentation was made by Col. William N. Campbell. Both the Governor and the Colonel were introduced by Hon. Harmon Allen of Springvale, Maine. After receiving his gift, the Doctor was greatly affected but finally got himself together and talked to some over twelve thousand people, for fifteen minutes, over the loud speakers. It was the first time in the history of the town that all stores, business and industry declared a holiday for the afternoon to do honor to the most lovable personality in this community.

New Member

Franklin

George Bowie, M. D., Rangeley.

Removal Notices

A. B. Allen, M. D., announces his removal from Waterville, Maine, to Piermont, New York.

William R. Tymms, M. D., announces his removal from Chebeague Island, Maine, to 130 North Greenleaf Avenue, Whittier, California.

E. M. Tower, M. D., announces his removal from Ogunquit, Maine, to 177 Main Street, Waterville.

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Coming Meetings

Kennebec County Medical Society, Frederick R. Carter, Augusta, Secretary.

September 15th, Waterville, *Dr. Howard Clute*, speaker.

October 20th, Central Maine Sanatorium, Fairfield, *Dr. Walter Bauer*, speaker.

November 17th, Waterville, *Dr. Louis A. Phaneuf*, speaker.

December 15th, Augusta State Hospital, *Dr. A. Warren Stearns*, speaker.

Vermont

Vermont State Medical Society, Burlington, October 6-7, B. F. Cook, Rutland, Secretary.

Necrologies

Harold Merle Goodwin,
1886-1938

Doctor Goodwin, 52, died at his home in Bangor, Maine, August 10, 1938, after a long disability. He had practiced general medicine and surgery in Bangor for the past seventeen years.

He was born in Danforth, Maine, on March 11, 1886, the son of Herbert and Ella May Goodwin, and early developed an ambition for all the education available with the medical profession in mind.

He received his preliminary education in the public schools of Old Town, Mattanawook Academy, Lincoln, and was graduated from Bates College in 1908. He received his medical degree from Harvard Medical School in 1913, after which he served an interneship at the Boston City Hospital.

When the World War broke out in 1914 Doctor Goodwin went overseas with the first Harvard Medical Unit and was with the British Medical Corps in a hospital of the Royal Army Medical Corps with commission as first lieutenant. In 1915 the Harvard Unit took over the American Red Cross hospital at Paignton, England, and Doctor Goodwin served a year when he was discharged and came back to the United States.

When this country entered the war he enlisted, again went overseas and was in the base hospital at La Tours, France, to the end of the war, returning with the rank of captain.

Following his return to this country, Doctor Goodwin did special work in the Providence Lying-In Hospital, and was, for several years, Chief Surgeon of the Employees' Liability Assurance Corp. of Boston. In 1921 he came back to Maine and located in Bangor as he had hoped to do because of his love for the outdoors and recreation.

Doctor Goodwin retained his interest in the Army Medical Service and at the time of his retirement had been for three years a Major in the 103rd Medical Detachment of the Maine National Guard.

He was a member of the American College of Surgeons, a member and past president of the Penobscot County Medical Society, a member of St. Andrew's Lodge of Masons and the American Legion. His religious affiliation was with the First Universalist Church.

It is needless to say that the passing of Doctor Goodwin is a matter of profound regret wherever he was known. Always giving his best to his profession, kindly and sympathetic, genial and popular with his many friends, a fine citizen in every way and most devoted to his family.

Surviving are his wife who was Gladys Colby of Bangor, twin daughters, Carolyn and Eleanor, and two brothers, Doctor Ralph A. Goodwin of Auburn and Virgil N. Goodwin of Bangor.

Sumner Bradbury Marshall,
1871-1938

Doctor Marshall, age 66, died at the Henrietta D. Goodall Hospital, Sanford, Maine, on June 1, 1938, of pneumonia, following a short illness.

He was born in Buxton, Maine, August 26, 1871, the son of Joel Meserve and Mary Tucker Marshall. He received his elementary education in the grade schools of Buxton and Gorham High School. He graduated from Bowdoin Medical School in 1898, and served a year in a maternity hospital in New York City. He started practice in the town of Shapleigh, Maine, where he remained for one year, and then moved his office to Alfred, Maine, where he practiced thirty-eight years, until the time of his death. He married Elizabeth Mary York of Bluehill, Maine, on June 22, 1909. He is survived by his widow and three children, two boys and a girl.

Dr. Marshall was Superintendent of Schools in the town of Alfred for a number of years; member of the School Board for twenty years; Health Officer in the town for thirty-five years. He was also York County Jail Physician for thirty-five years. He belonged to the Masonic Lodge.

He was loved by the entire community in which he practiced, and was very highly revered by his profession. It was often said of him that he never had an enemy.

Therefore, be it resolved, that in his death, the York County Medical Society has lost a valuable member, and the Town and Community in which he practiced, a highly respected citizen and doctor. Be it also resolved, that a letter of condolence be sent by this Society to his family.

Signed: H. D. Ross,
S. A. Cobb,
O. B. Head.

Forrest Hartley Badger,
1870-1938

Dr. Forrest Hartley Badger died suddenly at his home in Winthrop, Maine, July 13, 1938, of coronary thrombosis, at the age of 68. He was born in Rangeley, the son of James D. and Clementine A. Badger, and received his early education in the district schools of that town. He was graduated from Farmington Normal School in 1889, and taught school for a few years before beginning the study of medicine. He received his degree of M. D. from the Bowdoin Medical School in 1894, was instructor in surgical technique in Boston College of Physicians and Surgeons for one year and at the same time was assistant surgeon in the Pawtucket General Hospital. He came to Winthrop in 1898 after practicing in Strong and Rangeley. He had served as president of the Kennebec County Medical Association, and was a member of the Maine Medical Association.

He had served the town of Winthrop as superintendent of schools, and also as a member of the superintending school committee. He was instrumental in establishing and maintaining the Winthrop Community Hospital and after that institution closed he opened his own Private Hospital. He was always active in all matters concerning the welfare of the town.

He married Caroline M. Gilkey at Strong in 1897, who survives him, and he also has one daughter, Mrs. Marcia Reed, of East Greenwich, R. I.

William J. Trefethen, 1866-1938

Doctor Trefethen died at the Franklin County Memorial Hospital on July 24, 1938, from a cerebral hemorrhage and coronary occlusion following a six weeks' illness.

He was born at Wilton, October 20, 1866, the son of Joseph and Susan Webster Trefethen. His preliminary education was received at Wilton Academy and Kent's Hill Seminary. He attended Maine Medical College one year and then transferred to the College of Physicians and Surgeons at Baltimore, from which he obtained his degree in 1894.

He began practice in New Portland and four years later moved to Wilton, where he remained in practice up until the time of his death.

Doctor Trefethen was a member of the Franklin County Medical Society and Maine Medical Association. He belonged to the Masons, represented his district in the Legislature in 1921, and in 1923 served his county as senator.

Book Reviews

"Outline of Roentgen Diagnosis — An Orientation in the Basic Principles of Diagnosis by the Roentgen Method"

By Leo G. Rigler, B. S., M. B., M. D. Professor of Radiology, University of Minnesota, Minneapolis, Minn. Published by the J. B. Lippincott Company, 1938.

The modern medical student as well as the general practitioner is learning more and more that the indications, possibilities and limitations of the roentgen ray method of diagnosis represent one of the most important forms of knowledge in the medical field of the physical diseases. In this text, the reader's attention is directed chiefly toward that section of the roentgenologic specialty which is meant to perfect roentgenologic diagnosis in every disease process to which the method is applicable.

The book is divided into eleven sections. The first presents the general principles of roentgen diagnosis. The second to the fifth deal with diseases of the bones and joints, the spine and spinal cord, the skull and its contents, the thorax, and the digestive tract. Each section is introduced with a presentation of the normal characteristics of the particular organs; the remainder of it is devoted to the description of the characteristics of the various pathologic lesions. The last five sections comprise the roentgenologic procedures in the diseases of the gallbladder, the abdomen, the urinary tract, the female generative organs, and some miscellaneous topics on afflictions of the neck, the salivary glands, the seminal vesicles, the blood vessels, on calcification of arteries, lymph nodes, the thyroid, the spleen, etc.

This, the theoretical division of the work, is then brought to a more or less perfected logical completion in the pictorial division with its excellent illustrations.

The publishers of this work have also issued a Students' Edition, without the atlas, and with a paper cover. This edition includes all the textual material of the practitioner's edition but not any of the illustrations. This dual publication ought to greatly widen the marketability of the author's work, since the comparatively inexpensive flexible cover edition is almost ideal for student's use, while the regular library edition serves as a very welcome addition to the practioner's office library.

"The Technique of Contraception"

By Eric M. Matsner, M. D. Fourth Edition. Published by The Williams & Wilkins Company, Baltimore, Md., 1938.

This is the fourth edition of Dr. Matsner's most practical summary published by the National Medical Council. About 30,000 copies of the previous three editions are said to be already in the hands of gynecologists, obstetricians and general practitioners. The outline is being used as a supplementary text in courses in obstetrics and gynecology in 61 medical schools and is available in 213 medical libraries.

The author states that it must be constantly kept in mind that in this field of medical practice one is dealing with problems involving not only the physical, but the psychological, aesthetic and emotional variations in two individuals—husband and wife. This is no doubt one of the many reasons why we still do not possess the ideal contraceptive agent or method.

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Lewiston: *Central Maine General Hospital*—Tuesday, 11.00 A. M.-12.00 M. Director, *E. V. Call, M. D.*

St. Mary's General Hospital—Wednesday, 4.00 P. M. Director, *R. A. Beliveau, M. D.*

Waterville: *Thayer Hospital* — Thursday, 9.00-11.00 A. M. Director, *Edward H. Risley, M. D.*

Sisters' Hospital — Thursday, 9.00-11.00 A. M. Director, *Blynn O. Goodrich, M. D.*

Bangor: *Eastern Maine General Hospital*—Thursday, 11.00 A. M.-12.00 M. Director, *Magnus F. Ridlon, M. D.*

* Approved by Maine Medical Association.

Services to Crippled Children Clinic Schedule

Rumford: *Rumford Community Hospital*—1.00 P. M., 3.00 P. M., Wednesday: October 12th, November 30th.

Machias: *Washington State Normal School*—1.00 P. M., 3.00 P. M., Tuesday: October 4th.

Lewiston: *Central Maine General Hospital*—9.00-11.00 A. M., 1.00-3.00 P. M., Saturday: September 24th, October 22nd, November 19th, December 17th.

Bangor: *Eastern Maine General Hospital*—1.00 P. M., 3.00 P. M., Thursday: September 22nd, October 27th, November 17th, December 15th.

Portland: *Children's Hospital*—9.00-11.00 A. M., 1.00-3.00 P. M., Monday: September 12th, October 10th, November 14th, December 12th.

Presque Isle: *Northern Maine Sanitorium*—9.00-11.00 A. M., 1.00-3.00 P. M., Tuesday: October 25th, December 6th.

NOTE: Clinic notices will determine which schedule is being followed.

This schedule is subject to change at any time. If changes are made interested workers will be notified.

No Clinic appointments can be made for patients during the last five days prior to the Clinic except for cases who are referred in directly by physicians.

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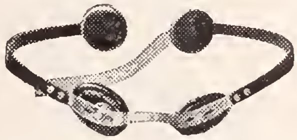

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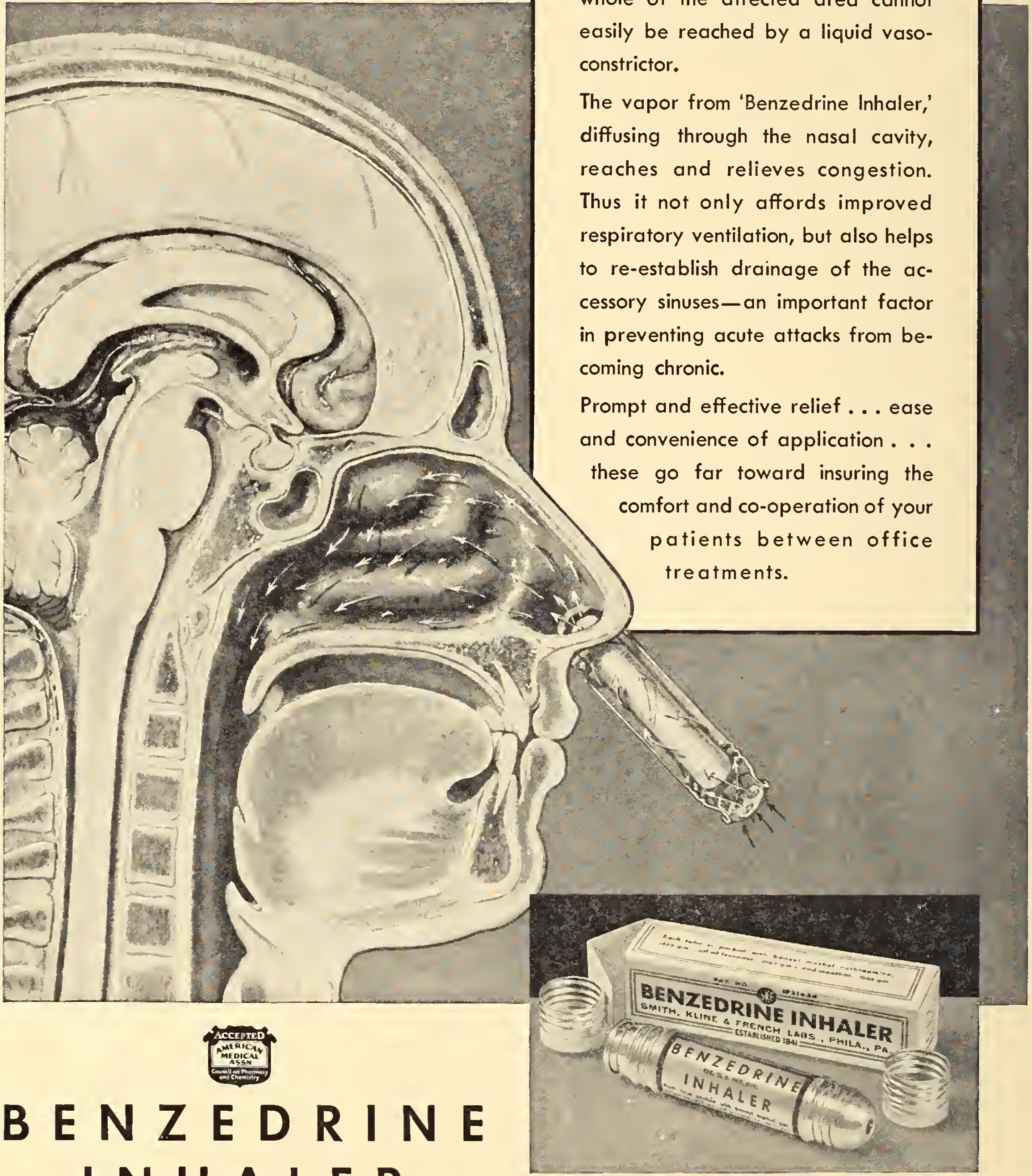

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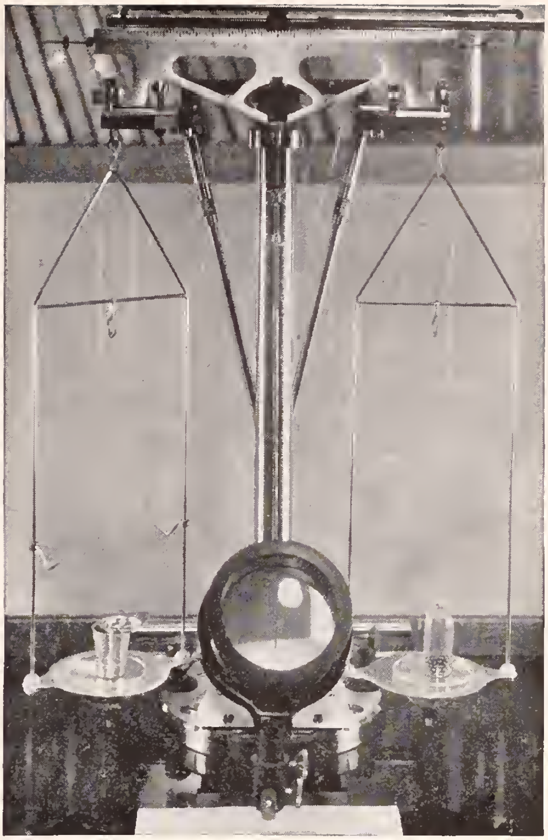

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RECENT ADVANCES IN THE SCIENCE OF NUTRITION

II. Newer Knowledge of the P-P Factor and the Control of Endemic Pellagra

● The years since 1932, when the P-P factor was known variously as vitamin B_2 or G, have been especially marked by contributions to our knowledge of the anti-pellagric vitamin. Considerable progress has also been made in the treatment of human pellagra as well as in the control of the disease. It might be of interest to review briefly a few of the outstanding developments in this field.

The P-P factor is now accepted as being closely related chemically to nicotinic acid if, indeed, it is not identical with that compound (1). Nicotinic acid has been used successfully in the treatment of human pellagra (2) and there is evidence to support the belief that the P-P factor is intimately associated with essential enzyme reactions in the body (3). A laboratory test has been devised for the early clinical detection of pellagra (4) and there is today better agreement as to the basic dietary requirements for the management of florid pellagra (1).

While the situation as regards endemic pellagra has, in general, shown improvement during recent years, an occasional report indicates that endemic pellagra still constitutes a major medical problem in some localities (5). Authorities agree that the old adage relating to an ounce of prevention being the equal of a pound of cure applies particularly well in the case of pellagra. Consequently, in specific regions of this country certain control measures have been advocated in an endeavor to bring this deficiency disease under permanent control. The most promising of these measures are the issuance of yeast rations and popular education to the desirability of home production of foods rich in the P-P factor, especially during late winter and early spring. The problem of permanent control of pellagra has been clearly and briefly defined as follows:

> "The prevention of endemic pellagra is simple in theory but difficult in practice. If every normal person received enough of the foods containing the pellagra-preventive vitamin there would be no endemic pellagra.—Permanent control can be obtained only by bringing about permanent changes in dietary habits" (1).

The correction of those long-standing dietary malpractices which are responsible for pellagra is certain to be brought about only slowly. The concerted and sustained efforts of all agencies concerned with public health will be required, not only to insure observance of the control measures described above, but also to educate the potential pellagrin to the necessity of a varied diet of protective foods.

Commercially, canned foods may play an important part in the current program designed to bring pellagra under control. Several hundred varieties of canned foods are readily available on every American market at all seasons of the year. Judicious inclusion in the diet of those foods known to be important carriers of the anti-pellagric factor (1) should materially assist in effecting permanent control of endemic pellagra in America.

AMERICAN CAN COMPANY
230 Park Avenue, New York, N. Y.

(1). 1938. J.A.M.A. 110, 1665.
(2). 1938. J.A.M.A. 111, 584.
1938. Ibid. 111, 613.
1938. Ibid. 110, 289.
(3). 1938. J.A.M.A. 111, 28.
(4). 1938. J. Med. Assn. State of Alabama. 8, 52.
(5). 1938. J. Med. Assn. State of Alabama. 7, 475.

This is the forty-first in a series of monthly articles, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research. We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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Maine Medical Journal

The Official Organ of

The State and County Medical Societies

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*Care of the Indigent Sick in the State of Maine**

By George W. Leadbetter, Commissioner of Health and Welfare, Augusta, Maine

For many years the Legislature of this state has appropriated money for use of private hospitals. The Legislature of 1915 appropriated the sum of $87,950 for use of 20 of these hospitals, varying in amounts from $500 to $27,500, and the resolves provided that these sums should be on account of maintenance of the several hospitals. At that time, it was customary for the state to pay the money to the hospitals in quarterly instalments.

The Legislature of 1917 appropriated approximately the same amount.

In 1919 the number of hospitals was increased to 26 and the amount of money to $104,650. In 1921 this was increased to $141,600 and remained about the same until 1927, when it was increased to $165,800 for 28 hospitals.

In the resolve which was passed by the Legislature of 1925 providing money for the fiscal years ending June 30, 1926, and June 30, 1927, there was a provision that the money should be used for medical and surgical treatment and care of children and adults, including children under sixteen years of age, but not including persons sixteen years of age and over, who, directly or indirectly, within a period of three months prior to receiving such treatment or care, had been supported or assisted as paupers, at not to exceed $17.50 per week, including direct payments from sources other than the state. The same provision appeared in the resolve for the two following years. While this provision has not been in the resolves since that time, it has still been the practice to use the money only for persons not having pauper assistance within three months, and any persons having pauper assistance within that time and requiring hospital treatment at the public expense could procure it only by applying to local overseers of the poor, and my understanding is that all hospitals have furnished such assistance in city and town cases at the regular ward rates.

The Legislature of 1929, by chapter 35 of the private and special laws of that year, changed the system by making a lump sum appropriation of $160,000 instead of making individual appropriations to each hospital. This act provided that the money should be used for the necessary care and medical and surgical treatment, at a rate not to exceed

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* Read before the 1938 Annual Meeting of the Maine Hospital Association held at Lakewood, August 31, 1938.

$2.50 per day per patient, in addition to any necessary emergency charges that might be approved by the state department of public welfare, of certain classes of persons whose resources, or the resources of whose responsible relatives, were insufficient to pay the same. It provided further that such money should be expended under the direction of the state department of public welfare. This act also provided that no other appropriation or use of public money should be made or authorized for the purpose of maintaining any hospital not owned or controlled by the state, except tubercular sanatoriums. The Legislature of 1935 increased this fund to $200,000 per year.

During the period from July 1, 1929, to June 30, 1933, the money was allotted to the various hospitals on the basis of free work done during the previous year and paid at the rate of $2.50 per day, plus special charges, as far as the money would go. The department of public welfare had nothing to do with the distribution of the fund until July 1, 1929.

Beginning July 1, 1933, the method of distributing the fund among the hospitals has been to divide it into quarterly instalments and pay the hospitals whatever amount the fund would allow per day on the basis of the number of days' free treatment given by each hospital. This system appears to be more satisfactory than the former system. Under the former plan the money was generally used up by the time the year was half over, which meant that there was no way in which the state could give treatment for the remaining half of the year. The result was that many persons who were unable to pay their hospital bills were obliged to become paupers and have their hospital treatment through the overseers of the poor at the expense of the city or town where they were living. No doubt many were treated by the hospitals without pay, and we know that a considerable portion of them simply went without needed hospital treatment; sometimes because they did not want to become paupers and sometimes because the towns were not in a financial position to furnish the aid.

Owing to the fact that the appropriation does not admit of paying full rates, one hospital, several years ago, refused to accept any more patients under this plan, and another refused at the beginning of this fiscal year. Quite a number of other hospitals have complained of the low rates, but have not definitely refused. During the fiscal year ending June 30, 1938, 42 hospitals accepted patients under the state plan and the total number of days' treatment given was 123,428, for treatment of 4,905 patients. The average payment for that year was $1.54 per day.

Under the present plan, the eligibility requirements for hospital aid are as follows:

a. Patient must have a settlement in the state or have lived here for one year prior to making application.

b. Patient or immediate family must not have received assistance through the overseers of the poor within three months prior to date of admission for treatment.

c. Patient or responsible relatives must be financially unable to pay in full a ward rate of $3 per day. In every case, an effort should be made to get the patient or relative to make partial payment according to his financial ability to do so even though it may be a small amount. In cases where payments by a patient plus payments from the hospital aid fund exceed $3 per day, the hospital aid fund should be reimbursed by the hospital for the amount which it receives in excess of $3 per day.

d. Chronic and incurable cases where a long period of treatment is needed will not be accepted. The bureau of social welfare reserves the right to discontinue payment on accepted cases after thirty days' treatment when due notice of discontinuance has been sent to the hospital.

e. Only one day's treatment will be allowed on T. and A. cases.

f. Out patients are not eligible for hospital aid.

g. Application for hospital aid must be made by the patient directly to the hospital where treatment is desired.

The department of public welfare went out of existence at the close of the year 1931, when the present department of health and welfare was established, and now the hospital fund is administered by the bureau of social welfare, which is one of the divisions of the new department.

Besides using this hospital fund, the state is paying out large amounts of money in other ways for hospital treatment for poor persons. During the fiscal year ending June 30, 1938, the expenditures in state pauper cases for such treatment were slightly over $100,000, which is 10% of the entire cost of support of state paupers, and during the same year, about $30,000 was paid out for hospital treatment in emergency aid cases, mostly in the St. John River valley, and approximately $10,000 for treatment of children committed by the courts to the care of the state, and the expense to the state for medical attendance, medicines, surgery, nursing and other items which may properly be classified as care of the indigent sick in these three groups, would add at least $50,000. These figures include treatment as poor relief for persons who cannot be classified as paupers because of military or naval service.

The expense of maintaining the three tubercular sanatoriums is about $432,000 per year, plus $45,000 for emergency tubercular work outside of these institutions.

Beginning with 1933 and in accordance with the provisions of the Code Bill, so-called, appropriations for the various departments are made in lump sums, but are based on the individual estimates added together. Of course the result is the same as if separate appropriations were made, except that the Governor and Council may allot the general appropriations to meet the requirements.

We should not overlook the fact that in addition to the amounts paid out by the state for treatment of the sick, cities and towns are paying large sums for such treatment for their city and town poor. Probably $300,000 to $350,000 per year would be a fair estimate. As a rule, there are about three city or town cases of this kind to every state case.

Under the law in this state, a settlement is acquired by five years' continuous residence in a city or town without poor relief during that period, and is lost by five years' continuous residence outside of that city or town without such relief. Persons who lose their settlement in this way and require assistance at the public expense, become state charges, unless a new settlement is acquired in some other city or town. It follows, of course, that persons moving into this state from some other state or country and falling into distress inside of five years become state charges, and persons designated as transients come within this classification whenever they require relief.

It should also be remembered that a considerable amount of the money paid out by the state in the form of old-age assistance, aid to the blind and aid to dependent children is used for medical attendance and medicines. At the present time there are nearly 15,000 of these cases, and the medical expense would probably average not less than $3 per month in each case.

Hospital patients, in any of the classes mentioned herein, are placed in the wards, as a general rule, and are treated according to the regular practice in the treatment of ward patients. They are not given any less consideration because their treatment is at the public expense or from funds which they receive as aid at the public expense.

Of course the majority of persons outside of hospitals who require treatment as poor relief are under the care of the local overseers of the poor, and are given whatever treatment they require in the judgment of the overseers, no matter whether they are city or town charges or state charges.

In many cases where families require assistance through the overseers of the poor, the need originates because of sickness or accident, necessitating immediate medical or surgical treatment, and the need for other forms of assistance, such as food, fuel, clothing and housing, is likely to follow in short order.

Probably sickness or accident is responsible for the need in more than one-half of the state cases, and it is reasonable to suppose that the same would be true in city and town cases.

In many states, the counties have duties and responsibilities as to care of the poor, but it is not so in the State of Maine.

Address of Dr. Irvin Abell, President of the American Medical Association, to Special Session of House of Delegates, Chicago, September 16, 1938

MR. SPEAKER AND MEMBERS OF THE HOUSE OF DELEGATES:

ARTICLE 2 of the Constitution of the American Medical Association reads as follows:

> "The objects of the association are to promote the science and art of medicine and the betterment of the public health."

SECTION I of the Principles of Medical Ethics reads as follows:

> "A profession has for its prime object the service it can render humanity: reward or financial gain should be a subordinate consideration. The practice of medicine is a profession. In choosing this profession, an individual assumes an obligation to conduct himself in accord with its ideals."

In these times of changing trends in social thought it is still well to adhere to those age-old principles as guiding lights in our efforts to furnish the American people with the best medical service obtainable. At the time of their adoption the form of society as a whole was comparatively a simple one: its evolution through the years has developed it into an exceedingly complex organization, involving changes in character of practice and distribution of service. During these years the medical profession has sought constantly to advance its standards in every direction that promotes efficiency and operates for the increased welfare of the people we serve. Drastic changes have been made in medical education, affording assurance that the graduate of today is competent and efficient; hospitals have been improved, insuring dispensation of service compatible with modern medical knowledge; the fields of specialization have been clarified and special training delineated for those desiring to register therein. The responsibility for the advancement of medical lore rests solely on the profession; its chief capital investment is represented by the constantly accumulating body of knowledge stored in the minds, ideals, traditions and publications of its members and which is shared freely with the public through universities, journals, discussions, the public press, radio and individual consultations. This capital cannot be monopolized for profit; it does not fit into the capitalistic concept of economics, yet it is the most valuable asset we possess. The Principles of Ethics by which we have been governed since the organization of the American Medical Association has been criticized as being obsolescent and antiquated. It is readily admitted that its underlying principles are ancient, but it is submitted that they are the only ones, whether in the ethics and economics of medicine or industry, that have stood the test of time. The medical profession by principle and tradition is committed to the idea that the prime object, the standard of value and the social reason for its existence are all one thing—the service it can render humanity. That service is further interpreted as the maintenance of health and the postponement of death. Whatever plan is proposed in regard to medical care is automatically tested and accepted or rejected by the profession in relation to its influence on the morbidity and mortality of the community or communities affected.

I beg your indulgence in thus briefly reviewing some of the fundamental, altruistic principles of the American Medical Association before proceeding to the matters pertinent to this special session of the House of Delegates.

PURPOSE OF THE SPECIAL SESSION

Following the passage of the Social Security Act, the President appointed an interdepartmental committee to co-ordinate health and welfare activities in order that the full benefits of the Federal program under the Act's provision may reach with minimum delay and maximum effectiveness the women, men and children for whose purpose the program was brought into existence. As you are aware, Miss Josephine Roche, chairman of this committee, announced in May, 1938, that a conference would be called in Washington to consider a national health program which had been developed by a sub-committee, known as the Technical Committee on Medical Care. Miss Roche was invited to attend the annual session of the House of Delegates, held in San Francisco in June, but found it impossible to attend. You heard her message, which was read to the House of Delegates and which is incorporated in the proceedings of the San Francisco session.

In accordance with the instruction of the House of Delegates some of the members and officers of the Association attended the National Health Conference and had opportunity to express your point of view. Those in attendance included your president, Dr. Irvin Abell of Louisville, Kentucky; the secretary of the Association, Dr. Olin West; the chairman of the Committee on Medical Service, Dr. William Braasch of Rochester, Minnesota; the chairman of the Committee on Scientific Assembly, Dr. James Paullin; the chairman of the Council on Industrial Health, Dr. Stanley Seeger; Dr. Arthur Booth, chairman of the Board of Trustees; the Editor of *The Journal,* Dr. Morris Fishbein, and several presidents and secretaries of state societies. The newspapers and periodicals have reflected to some extent the attitudes of those who were in attendance at this conference. The members included physicians and representatives of correlated professions who were in a distinct minority, numbers of representatives of labor organizations, mutual aid and welfare organizations, farm bureaus and federations, publicists chiefly associated with liberal and radical periodicals, leading workers in the field of the hospital and of hospital insurance organizations, and governmental employees.

The Board of Trustees will no doubt present to you an outline of the National Health Program which was presented to the National Health Conference. It is for you to consider the various aspects of this program and to determine to what extent the American Medical Association shall endorse or oppose the various phases of the plans proposed. Bear in mind that the National Health Conference did not itself come to any definite conclusions. The program was set forth and largely supported by representatives of various governmental departments. Many of the lay members in attendance gave unqualified endorsement to the program as a whole or in part. Representatives of the American Medical Association, however, were unanimous in stating that they had no authority to take action on any part of the program or on the program as a whole but rather that this was a function of the House of Delegates, the representative body of the American Medical Association, and that at a later date this program would be submitted to the House for its consideration.

During the National Health Conference no attempt was made to elicit, nor was opportunity given for, the presentation of alternative programs or for detailed discussion of all or any part of the program. If there seemed to be any single proposal on which all of those present were in agreement, it concerned the demand for a cabinet position on health and medical service under which all of the health and medical services of the government might be united. As our government is now constituted, appropriations to put into effect various parts of the program may affect legislation involving half a dozen or more Federal bureaus.

Need for Wider Dissemination of Accomplishments

The medical profession of the United States faces a situation which is unique. Without calling the organized medical profession, or any considerable representation among those engaged in practice, into conference, a vast plan affecting health and medical care has been proposed to the people. In the forwarding of this plan forces of propaganda have apparently made a studied effort to indicate that the American Medical Association opposes all change and that it is essentially a stand-pat organization. There would seem to be need at this time for a wider dissemination of the truth as to what has been accomplished by the American Medical Association for the people of this country and as to its true attitude toward the changes that are occurring in and that are being proposed for the medical care of our people.

Policies of the American Medical Association

The American Medical Association has constantly recognized the need for continued expansion of preventive medicine and a wider use of medical care. It has, however, at the same time been greatly concerned with the methods of administering both preventive medicine and medical care and with the ultimate effect of various changes on the morale as well as on the health of our people. The charge that is sometimes made, and which was made by radical speakers during the Health Conference, that physicians oppose changes because of a desire for more and more money is an outrageous misstatement of our attitude. It is a fundamental tenet of the American Medical Association that the poverty of a patient should demand the gratuitous services of a physician; but endowed institutions and organizations for mutual benefit or for accident, sickness and life insurance or for analogous purposes have no claim upon physicians for unremunerated services. As a professional man the individual physician has a right to determine the conditions of his service.

It is a fundamental tenet of the American Medical Association that it is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient because, to do this, is detrimental to the public. It is established as a principle of our organization that it is unprofessional for a physician to dispose of his professional attainments or service to any lay body, organization or group or individual by whatever name or however organized under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure has been established as beneath the dignity of professional practice, as unfair competition with the profession at large, as harmful alike to the profession and the welfare of the public, and as against sound public policy.

Experimentation with New Forms of Practice

Within these fundamental tenets experimentation in new forms of medical practice has not been inhibited. Hundreds of experiments have been carried on in the past and are now being carried on under the auspices of medical societies which are component parts of this organization, planned distinctly with a view to securing a wider distribution of medical service and to making more and more medical care available to a greater number of people. Thus the American Medical Association has never opposed the principle of group hospital insurance, notwithstanding repeated attempts by those who would place the Association at a disadvantage, in asserting that this House of Delegates has opposed this principle. The American Medical Association through its component societies has frequently given aid to the development of group hospital insurance, asking only proper safeguards for the patient and for his physician in the development of such plans.

Care of the Indigent

The Association has never opposed suitable care by municipal, county, state or other governmental agencies for the indigent or for those on the borderline of indigency. It has urged state, county and other medical societies to develop "the most accurate and complete information that will enable them to maintain continuous medical care that is sufficient in amount and satisfactory in quality."

State Interference with Medical Practice

The Association has constantly opposed the adoption of any form of state medicine by any definition of that term; and it has refused to endorse vague plans that would make the care of the indigent and of those on the borderline of indigency, or those well able to pay, a burden on the workers of this country. The American Medical Association has never opposed suitable participation by the government through any of its agencies in preventive medicine or in any legitimate function of government in relationship to the care of the sick. By and with the aid of local, county, state and national medical organizations, the United States Public Health Service has been enabled to carry out far-reaching plans for the control of venereal disease, for pneumonia, for cancer, for the expansion of personal and public hygiene and for the prevention of infections. Without such participation these accomplishments would never have been attained.

Medicine Not in Politics

The American Medical Association and its constituent bodies have constantly opposed any attempts on the part of local, county, state or federal governments to make medical care a political issue. American medicine fears political bureaucracies. It fears the acceptance of European models which have been set up by various so-called philanthropic foundations in an attempt to socialize medical practice in this country. The medical profession of this country wishes to keep the practice of medicine within the medical profession. It does not conceive that any political agency can do the job with one-tenth the efficiency at ten times the cost.

The Principle of Insurance

The American Medical Association has never opposed the principle of insurance. An organization such as ours is in itself of the nature of a coöperative group in which individuals have banded together and by their individual contributions have made possible great accomplishments which individually they could not have attained. It is not the principle of insurance that is opposed by American medicine. The principle which we do oppose is political administration and manipulation of the insurance organization, devotion of a considerable portion of the funds thus derived to the payment of great numbers of employees not directly concerned with the service, but intimately concerned with the maintenance of a political organization, and expansion of such organizations to wield greater and greater power in the nation's affairs.

The American Medical Association has not opposed insurance against the costs of sickness, of disability, of unemployment, of old age, or of death. It does oppose any interference by any outside agency—commercial, governmental or otherwise—into the relationship between doctor and patient which is fundamental in good medical care.

Personal Relationship Between Doctor and Patient

We have recently heard the statement that the worth of this relationship is a fancied one, yet it possesses reciprocal qualities that inure to its value both to the physician and to the patient. With the realization by the physician that the patient in selecting him for personal service has demonstrated a confidence in his ability and integrity comes a determination to justify such trust by giving service to the best of his ability. The family physician knows the ancestry and heredity of the patient, is familiar with his temperament, the conditions under which he lives, his financial and emotional worries and has a sympathetic attitude toward his problems, collective knowledge that has a definite value in carrying one through the crises of illness and in thwarting or minimizing the encroachment of disease.

In the National Health Conference a number of speakers who participated drew a picture of the American people in which perspective was largely lost. They showed us as a nation in which not only are one-third of the people ill-fed, ill-housed, and ill cared for in sickness, but a nation with numbers of people dying for the lack of medical care, suffering agonies because unable to purchase medical care and unwilling to consult a physician for the fear of the costs of such consultation. The presentation of this perspective without suitable correction was unfair, not only to the medical profession of this country but also to the people of this country.

There is need for far more factual knowledge than is thus far available. An attempt to secure such factual knowledge is being undertaken by the American Medical Association as a part of its nation-wide survey of medical care. The reports of some of the counties already published in *The Journal* indicate that it is possible to make this survey an accurate picture of the status of medicine in every portion of the country. Without such a picture it is impossible for any agency to develop suitable scientific legislation to meet the actual needs that exist.

It is proposed that at the next convening of the Congress of the United States legislation will be introduced to put into effect the proposals involved in the National Health Program. It is a function of this House of Delegates to consider carefully the proposals that are made so that your representatives, your elected and employed officers may carry into effect your point of view and to bring that point of view suitable to the elected representatives of the people.

House of Delegates Speaks for Profession

Only this body speaks for the American medical profession as a whole. It is no secret that there has been an attempt in various places to lead the American people to believe that the American Medical Association is not representative of the American medical profession, that it is a weakened, disrupted, and failing organization. The actual fact is that the Association speaks today with the greatest membership in its history. During the year 1937-1938 it gained more than 4,000 members, reaching a total of 109,435 in its membership.

When your decision is made during this special session of the House of Delegates, it will be broadcast by the press and by your own organs of expression to the people and the medical profession in this country. The principles and policies which we have thus far established do not forbid, nor have they ever contemplated any opposition to a well considered, expanded program of medical service, when the need can be established. Neither is there any fundamental principle or policy which in any manner opposes aid to the indigent or the medically indigent, if their indigency can be established. The principles and policies which this House of Delegates has adopted in the past have been developed with the single purpose of maintaining the quality and standards of medical care. To these high ideals I would urge you again to adhere. I would urge you also to consider seriously the obligation which rests upon you, so that you may speak, when you do speak, with a united voice, and so that by and with your leadership the physicians of this country may also speak with a united voice in behalf of greater medical service and a greater medical profession.

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*Indiana Suggests a Workable Plan to Protect the Health of the People of the United States**

The "Indiana Plan" of preventive medicine was presented to the American Medical Association at San Francisco with the suggestion that it be expanded into a national program. The proposal was approved in principle by the House of Delegates.

Inaugurated January 1, 1938, the Indiana State Medical Association's program, described as "an idealistic effort to safeguard the health of all individuals," already has attracted the attention of national authorities on health and medical problems.

With *The Journal* of the state association as a central forum for an educational program conceived to prevent illness, county medical societies have concentrated each month this year on a specific disease or health problem of paramount public importance. Coördinating their work with the program of the Indiana State Board of Health, the various societies have furthered their educational work through luncheon clubs, parent teacher associations, and other lay civic organizations.

The program is outlined in the following material, reprinted from *The Journal of the American Medical Association*, Volume 111, No. 1, page 49.

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* Reprinted in part from *The Journal of the American Medical Association*, July 2, 1938, Vol. 111, pp. 49-51. Copyright, 1938, by American Medical Association.

Resolution Approving in Principle the Indiana Plan of Health Education and Preventive Medicine

Dr. H. G. Hamer, Indiana, presented the following resolution, which was referred to the Reference Committee on Medical Education:

> Whereas, A pressing need exists for the development of a national policy on the part of organized medicine to bring the benefits of preventive medicine to all the people; and
>
> Whereas, The medical profession, through its local county and state medical societies, already has made tremendous progress in developing programs local in scope; and
>
> Whereas, A program of professional and lay health education is now functioning successfully in Indiana; and
>
> Whereas, The profession in controlling tuberculosis, malaria, typhoid, diarrhea, yellow fever, puerperal sepsis and other infectious diseases has been largely responsible for the present favorable morbidity and mortality rates; and
>
> Whereas, It is essential to make preventive medicine an integral part of organized medicine and individual private practice; and
>
> Whereas, In order to put into immediate action at this session of the House a suggestion so ably stated on numerous occasions that "the attention of state and county societies should be drawn to the opportunity of assuming a definite leadership in the respective states and counties and directed with the best ideals of medicine and the best interests of the public"; therefore be it
>
> *Resolved*, That the House of Delegates of the American Medical Association approves in principle the Indiana plan, a copy of which follows, of health education and preventive medicine and directs the Bureau of Health Education of the American Medical Association to bring this plan to the attention of the medical profession and the lay public through all available channels.

TWO BIRDS WITH ONE STONE

(THE TWO BIRDS "DISEASE" AND "SOCIALIZED MEDICINE")

INDIANA SUGGESTS A

WORKABLE PLAN

TO PROTECT THE HEALTH OF THE

PEOPLE OF THE UNITED STATES

An Antidote for State Medicine

Frequently today the physician finds articles in the press questioning his efficiency and his methods of practice. Such articles accuse him of ignoring preventive medicine in his daily work. He is bewildered and defensive in his attitude, for he feels that he is doing his job well. Even superficial observation will disclose the marked drop in death rate as a result of measures instituted by the medical profession in controlling tuberculosis, malaria, typhoid, diarrhea, yellow fever, puerperal sepsis and other infectious diseases. Preventive medicine is now being practiced by all physicians as private practitioners to some degree. In many parts of the state, county medical units have a definite program. The time is ripe to correlate these scattered activities, survey our local situations, and acquaint the public with the extent of this phase of our work.

Many phases of preventive medicine have advanced by stimulation from outside groups. Drives have been sponsored with much misunderstanding. Preventive medicine has now reached its maturity and should be utilized to the fullest by organized medicine and by the individual doctor. It is futile for one county or state to try to promote this alone. Disease and disaster are not aware of state borders. A national policy on the part of organized medicine is needed now.

Too long have we kept our light under a bushel. It is time to take the offensive. The amount of preventive medicine can be increased by the private practitioner with definite benefit to his community and to himself, and the public will be made to realize that American Medicine is pliable enough to continue as an individualistic enterprise.

Throughout the ages, medicine has adapted itself to social changes. We are now in one of those states of changing social customs and aspirations. The American public looks to organized medicine for leadership. Prevention of disease, early recognition of defects and diseases, reduction of hazards and prolongation of life are the important functions of a physician.

In Indiana we have visualized preventive medicine as a wheel with each spoke representing some important phase. Each phase is featured as a "Topic of the Month" in the *Journal of the Indiana State Medical Association* and is announced or discussed in each county medical society the month the subject is featured. The topic of the month is given support in the press and is discussed by speakers before medical and lay groups.

Topics of the Month

January—Formulation of Plan.

February—Syphilis.

March—Pneumonia.

April—Diphtheria.

May—Maternal and Child Health.

June—Crippled Children.

July—Highway Accidents.

August—Occupational Diseases.

September—Annual Physical Examinations and Heart Disease.

October—Conservation of Eyesight.

November—Tuberculosis.

December—Smallpox.

Purpose

To promote aggressive leadership by Organized Medicine in Prevention of Disease and early detection of defects.

To incorporate preventive medicine as an important phase of private practice and of county medical activity.

To promote a National Health Program with emphasis on Prevention of Disease sponsored by the American Medical Association with due regard for local situations.

Our modern age demands coöperative efforts by organized medicine to distribute modern medicine.

Dividends or Results

1. Create good will and public approval.
2. Raise general standard of medical practice.
3. Prevent many deaths and much suffering.
4. Give a better ordered life for the doctor.
5. Give a steadier income for the doctor.
6. Intelligent defence against disease is our best defense against government encroachment.

Alternative

Noisy and aggressive lay groups will seize leadership and we will trail behind, cloaked with heavy governmental supervision.

Syphilis

"No Baby Born with Syphilis in Indiana by 1940"

Can be controlled by:

1. Premarital examination including blood test.
2. Blood test early in every pregnancy.
3. Making good treatment available to all.
4. Good laboratory service available to all.
5. Reporting of new cases by name or number to health department.
6. Tracing contacts by trained social investigators.
7. Free distribution of drugs for medically indigent patients.
8. Isolation of infectious, non-coöperative cases.
9. Making provision for infectious transient or itinerant.
10. Coöperation of private physicians and public clinics.
11. Developing and popularizing a minimum standard of treatment for early syphilis.
12. Continuing the educational program among medical and lay groups.
13. Helping the Negro solve his syphilis problem.
14. Spinal puncture on every treated case.
15. Spending the syphilis dollar where it counts.

Pneumonia

1. Leadership by the medical profession in developing a complete pneumonia program for all the people.
2. Recognition by the physician of the importance of early diagnosis and early treatment of pneumonia and the use of life-saving types of serum.
3. Development of facilities so that typing may be done within four to six hours.
4. Appointment of committees by state and county medical societies for special studies in pneumonia.
5. Adequate nursing care for home cases.

6. Development of adequate hospital facilities.

7. Education of the public as to the gravity of the whole pneumonia problem, and the fact that the common cold often is an antecedent for pneumonia.

8. Education of the public as to what may be expected if pneumonia is properly handled.

9. Formation of serum "banks" in order to supply serum immediately and free to the indigent or on proper credit to those who are solvent but incapacitated.

10. Try to lower the cost of present forms of treatment.

11. Usual well established supportive treatment indicated in addition to serum treatment.

12. Teach the physicians generally the importance of early typing of every suspected pneumonia.

DIPHTHERIA

1. Immunization of every child at 1 year of age by family doctor.

2. Accomplished by following plan:

> When child is 1 year of age local health officer sends a double postcard to the parents stating that it is the judgment of organized medicine and health authorities that now is the time to immunize the cild against diphtheria and to see the family doctor at once. When the injections have been completed the doctor returns the second half of the card to the health officer.
>
> If immunization of the child is unpractical from the standpoint of (1) finances, (2) moved away, (3) death of child, (4) religious objection of parents, the parents are asked to check and return. The medically indigent are handled according to the customs of the community.

3. When child enters school he receives a Schick test or another injection of toxoid.

No Drives—No Misunderstandings—Constant Pressure.

MATERNAL AND CHILD-HEALTH

"SAFE MATERNITY—HEALTHY CHILDREN"

1. Good antepartum care available to all.

2. Nursing assistance at home deliveries.

3. Continued study of the causes of maternal and infant mortality by organized medicine.

4. Inquiry as to cause of each individual death by the state committee and hospital staff.

5. Immunization program for all children.

6. School health programs—physical health education—distribution of literature on health.

7. County public health nursing program under medical advisory committees of local counties.

8. Mental hygiene program for children.

9. Dental educational and reconstruction program.

10. Postgraduate work for physicians, dentists and nurses.

CRIPPLED CHILDREN

"CORRECT REMEDIAL DEFECTS EARLY"

1. Include in birth certificates the presence or absence of congenital defects.

2. Coöperation of state medical association through advisory committee.

3. Nurses contact physicians, who report cases.

4. Early consultation made available to all.

5. Children treated in approved hospital near home if possible.

6. Schools for crippled children in the larger cities.

7. Reciprocal arrangements between states for transient crippled children.

8. Find and offer aid to the older crippled child.

HIGHWAY ACCIDENTS

1. A study by organized medicine of the causes of death from highway accidents.

2. Assist the law enforcement agencies in reducing the hazards of the careless and drinking driver.

3. Aptitude test on the repeating offenders.

4. Probationary period for young drivers.

5. Coöperate with the American Red Cross in first aid instruction.

6. Filling station attendants to be given instruction in first aid.

7. Develop protection for the doctors and hospitals from irresponsible injured.

OCCUPATIONAL DISEASES

Occupational diseases form approximately 2 per cent of the total disability from industrial causes.

1. Assist employers to cope with employees' health problems with coöperative attitude on the part of the medical profession.

2. Preemployment thorough physical examination.

3. Periodic health examination. (If routine blood tests are made on the employees, treat—don't fire.)

4. Majority of occupational diseases are skin infections, many of which are preventable.

5. Patch testing of employees in occupations producing dermatitis will greatly decrease illness.

6. Teamwork of industrial physician and general practitioner is very desirable.

7. Industrial physician should direct patients with diseases other than those resulting from employment into the channels of ordinary practice.

8. Find the job that best fits the employee physically.

9. Use existing hospital facilities as much as possible.

ANNUAL PHYSICAL EXAMINATION AND HEART DISEASE

1. Educate physicians in better recognition of heart disease.

2. Teach the newer methods of studying functional capacity of the heart.

3. Teach the seriousness of "mild" infections as a background for heart crippling.

4. Teach the role of weight, heredity and environment in the production of hypertension.

5. Educate the physician and layman as to the seriousness of rheumatic infections.

6. Continue to emphasize the role played by syphilis in the problem of heart disease.

7. Train heart cripples of all ages in pursuits that permit them to accommodate their defects.

8. Educate physicians and the public in the importance of periodic examinations.

9. Urge the need for careful periodic examinations after middle life.

10. Stress the need for certain laboratory and x-ray studies at regular intervals: urinalysis, serologic, electrocardiographic and similar laboratory procedures.

CONSERVATION OF EYESIGHT

1. Ophthalmia Neonatorum. Prevent by prompt instillation of silver nitrate, 1 per cent or 2 per cent solution, into the eyes of the newborn.

2. Squint or crossed eyes. Begin treatment not later than age 2.

3. Discourage the use of high explosive fireworks in the hands of children. Reduce fourth of July eye injuries.

4. Examination of school children for visual defects.

5. Avoid eyestrain. A. Correct visual defects. B. Present and treat diseases of the eye. C. Install proper lighting. D. Reasonable use of the eyes according to effects of use.

6. Help reduce hazards from industrial accidents.

7. Early detection and treatment of syphilis will reduce blindness.

8. Wipe out trachoma in Indiana.

Tuberculosis

1. Physical examination of every child at age 16, including tuberculin test.
2. Thorough physical examination on entering college or industry.
3. Examination of all nurses on entering training and recheck at regular intervals.
4. X-ray available for positive reactors.
5. Trace contacts and examine.
6. Protect the community from infectious cases by adequate number of hospital beds.
7. Concentration on detection of early cases.
8. Coöperation with antituberculosis association and public health nursing organizations.
9. Continue educational program in high schools.
10. Use collapse therapy when indicated.
11. Rehabilitation program.

Smallpox

1. Vaccinate every child at age of 1 year after completion of diphtheria immunization.
2. Vaccinate again on entering grade school and thereafter at regular intervals by the family doctor.

Extend the scope of preventive medicine to include other infectious diseases and metabolic disturbances as methods are proved to control them.

The Individual's Medical Service Chart Through Life

Three Months Pregnant	
Measurement of pelvis Blood pressure—urine Wassermann test	Reduction in maternal mortality Prevention of congenital syphilis
At Birth	
Silver nitrate in baby's eyes	Prevention of blindness (ophthalmia neonatorum)
First Week	
Physical examination of baby	Recognition and correction of remedial defects
First Year	
Correct infant feeding	Prevention of diarrhea-rickets and scurvy
One Year of Age	
Immunization and vaccination	Prevention of diphtheria and smallpox
Two to Fifteen	
Annual check-up by the family physician	Individual health education
Sixteen Years	
Physical examination with special attention to lungs	Prevention and early recognition of tuberculosis
Before Marriage	
Premarital examination	Recognition of venereal diseases
Adult Life	
Annual physical examination	Prevention of heart disease

Reduction in Hazards

1. Venereal disease
2. Pneumonia control
3. Highway accidents
4. Typhoid
5. Nervous disorders
6. Occupational disease
7. Cancer

Bureau of Publicity
Indiana State Medical Association
1021 Hume-Mansur Building
Indianapolis, Indiana

Report of Reference Committee on Medical Education

Dr. William D. Johnson, Chairman, presented the following report, which was adopted on motion of Dr. Johnson, seconded by Dr. J. Newton Hunsberger, Pennsylvania, and carried after discussion:

Your reference committee, having studied the Resolution Approving in Principle the Indiana Plan of Health Education and Preventive Medicine, offered by Dr. H. G. Hamer at the morning session, commends the resolution and moves its adoption.

Respectfully submitted,

William D. Johnson, *Chairman.*

The President's Page

To the Members of the Maine Medical Association:

On July 11th, at 2.30 P. M., the Council of the Maine Medical Association met at the Elmwood Hotel at Waterville to instruct our delegate, Dr. William A. Ellingwood of Rockland, Maine, relative to his visit to Chicago to attend a meeting of the House of Delegates of the A. M. A. for the purpose of discussing the National Health Program. After a long conference it was voted that Dr. Ellingwood should go uninstructed with the assurance of the Council that any decision made by him would be upheld by that body.

For the information of the members of our Society I will say that Dr. Ellingwood, our delegate, Dr. Frederick Carter, our State Secretary, and Dr. Frank Jackson, the Editor of our State JOURNAL have all attended the meeting held at the Palmer House in Chicago, on September 16th and 17th, and from information I have at hand the results will be very satisfactory.

Everything was done by committees, as a result of which the House of Delegates agreed with the interdepartmental committee on many of the major principles with a few modifications.

They agreed that the health of the impoverished patients should be protected by the use of Federal and State funds, they opposed the building of additional hospitals where they were not needed but indorsed the better use of existing hospitals. They endorsed plans for Hospital Service Insurance but opposed Compulsory Health Insurance. They urged the expansion of Workman's Compensation Laws but recommended that the complete care of the indigent is the responsibility of the community and care should be organized by Government units and supported by tax funds.

As a result of the conference, a Committee of the A. M. A. was appointed to meet with a committee of the Federal Government to discuss and make recommendations which will be presented at the next term of Congress.

In closing I would like to emphasize the fact that one hundred sixty-five out of one hundred seventy-four delegates were present, besides the Editors and Secretaries of State Associations and the officials of the A. M. A.

This should be an example for our delegates and County Secretaries to follow in our own State Society.

W. H. BUNKER, M. D.

Editorial

Lest We Forget

Some time ago notice was served in no uncertain manner that organized medicine was to be investigated, shown up and measures taken to assure that dissipation of the influence of the American Medical Association would be a fact. Within the past few months a Deputy Commissioner of Revenue ruled that the Association is not a scientific or educational organization but is a business league and, therefore, not exempt from tax under the Social Security Act. Such a ruling, most delicately timed, was followed by the project to liquidate the Association under the Sherman Act.

It might be well for those who would radically change the existing order of things in the practice of medicine, and there is no monopoly on the diversity of the plans, legislative or otherwise, that are being proposed for the care of the sick, to consider what organized medicine has accomplished in the last quarter of a century. Out of its own funds, with no gratuities asked for or received, it has contributed well over a million dollars to raise and progressively increase the standards in medical education; quackery has been exposed and to a great extent eliminated and with no lessening of effort it has demanded and obtained a degree of hospital standardization until today this country stands second to none in educational opportunities for the study of medicine and the care of the sick. Any legitimate request on the Association, or its constituent societies, to bring the best possible medical care to the people of this country has been met and usually anticipated.

Certain questions naturally arise in the minds of those who have been delegated by their County, State and National Societies to carry out their official assignments. Why all this criticism, which is not founded on facts, and valid and worthwhile opinions must be so based. Have we as physicians and citizens fallen down on our job; have we become "money mad" and are allowing millions to die or suffer because it costs too much to have a doctor; are we conducting our various professional societies along the lines of a "plumbers' union," as has been said, and have we become forgetful of the fact that we are entrusted with the most valuable asset of this nation, the health of the people?

The recent National Health Conference had as its stated objective two essential ends: National needs in the field of health and medical care and the formulation of policies which would enable the profession of medicine, and all other interested and competent agencies, to coöperate in an effort to meet them. So far such needs have not been established so as to present the correct facts. It is important and timely to remember that the Legislative powers of the American Medical Association reside by constitutional provision in the House of Delegates. On the shoulders of that organization rests the fate of American medicine and the health and safety of the people of this country. We have not and will not depart from democratic methods of solving the problems that not only concern us but the public we serve. Self appointed and anointed critics within our ranks, collectively or individually, may arrogate to themselves an authority and importance that may be pleasing to some but conceded not at all by the profession as a whole.

"The wise and discerning will recall that the fathers did not fight against giving overriding authority to men of evil intentions. They fought against giving overriding authority to ANY men."

* * * * *

Attention

Attention of the Members is called to the most excellent program prepared by the Clinicians of the Hospitals in Lewiston to be presented at the Fall Clinical Session.

Program

Clinical Session of the Maine Medical Association

Lewiston, Maine

Thursday and Friday

November 3rd and 4th, 1938

St. Mary's General Hospital Lewiston, Maine Thursday, November 3rd	Central Maine General Hospital Lewiston, Maine Friday, November 4th
MORNING SESSION 8.00 A. M. to 10.30 A. M. Surgical Clinics 10.30 A. M. to 12.00 M. Clinical-Pathological Conference Dr. Romeo A. Beliveau Discussions by Dr. Mortimer Warren, Dr. H. E. Thompson, Dr. Julius Gottlieb	MORNING SESSION, 9.00 A. M. to 12.00 M. Surgical Clinic: Dr. William J. Fahey Dr. William V. Cox Dr. George E. Young Dr. Gilbert Clapperton: Demonstration of Cyclopropane, Spinal and Endotracheal Anesthesias Clinic Room: *Fifteen-Minute Presentations* Dr. E. V. Call: Case Presentations—Myelogenous Leukemia, Carcinoma of the Lip Dr. C. H. Rand: Case Reports Dr. W. P. Webber: Case Reports
12.00 M. Luncheon at the Hospital	12.00 M. Buffet Lunch at the Hospital
AFTERNOON SESSION 1.30 P. M. to 2.30 P. M. Presentation and Discussion of Orthopedic Surgical Cases Dr. H. L. Gauvreau 2.30 P. M. to 2.55 P. M. Causes and Treatment of Congestive Heart Failure Dr. Bertrand Beliveau 2.55 P. M. to 3.20 P. M. Gynecological Subject to be announced 3.20 P. M. to 4.20 P. M. Presentation of Cases (3) with Unusual X-ray Findings Dr. Camp C. Thomas 4.20 P. M. to 4.55 P. M. Frequency and Types of Thyroid Disease in this Locality Dr. George B. O'Connell 4.55 P. M. to 5.20 P. M. Eye Findings in Relation to Brain Tumors Dr. Jerome Sansoucy	AFTERNOON SESSION: 2.00 P. M. to 5.00 P. M. Clinic Room: *Fifteen-Minute Presentations* Dr. R. A. Goodwin: Case Reports Dr. J. Gottlieb: A Method for Coronary Volume Estimation Dr. H. Sprince: Endocrines in Irregularities in Menstruation Dr. W. V. Cox: Case Presentation — Postoperative Patient with Artificial Larynx Dr. M. S. F. Greene: Case Reports—Influenzal Meningitis Dr. E. L. Pratt: Bronchoscopy and Esophagoscopy Dr. W. J. Renwick and Dr. C. W. Steele: Criteria for the Diagnosis of Coronary Disease—Illustrated by Moving Pictures Dr. S. E. Sawyer and Dr. G. Clapperton: Symposium on Anesthesiology with Exhibit of Main Types of Anesthetic Equipment Used, Oxygen Therapy and Blood Transfusions
3.00 P. M. to 5.00 P. M. Tea for Ladies	3.00 P. M. to 5.00 P. M. Tea for Ladies

THURSDAY EVENING at 7.00 O'CLOCK

Dinner at The DeWitt Hotel

(Ladies Invited)

Speaker: Dennett L. Richardson, Superintendent of Charles V. Chapin Hospital, Providence, Rhode Island

Subject: Contagious Disease Hospitals

Members will Please Register; Thursday at the St. Mary's General Hospital
Friday at the Central Maine General Hospital

Correspondence

THE MASSACHUSETTS MEDICAL SOCIETY
Executive Offices
8 Fenway, Boston, Mass.
Telephone: KENmore 2094

August 15, 1938.

DR. FRANK H. JACKSON, *Chairman*
Maine Medical Journal
22 Arsenal Street
Portland, Maine

Dear Dr. Jackson:

The Massachusetts Medical Society is planning to sponsor a Postgraduate Assembly to be held in Boston on November 15 and 16. The medical profession of the states of Massachusetts, Maine, New Hampshire, Vermont and Rhode Island will be officially invited. A program will be mailed to every doctor in these states early in September.

The committee wishes to invite you to be a guest of the Society at this Assembly during these two days.

A program will be mailed to you as soon as it is off the press.

Very sincerely yours,

LEROY E. PARKINS, M. D., *Secretary,*
Executive Committee on Postgraduate Instruction.

LEP:ES

Full Program will appear in the November JOURNAL.

County News and Notes

Cumberland

Benjamin B. Foster, M. D., announces his removal from 142 High Street to 300 Danforth Street, Portland. Associated with Doctor Foster is *Leon Babalian, M. D.*, graduate of the Medical School of the University of Paris, Assistant at St. Louis Hospital of Paris (1927-1937), member of the Society of Dermatology and Syphiligraphy of France (1924). Author of several treatises of the following subjects: Latent biliary retentions in Syphilis; Physiological mechanism of the nitritoid crisis, and possibility to foresee this crisis; Syphilitic acroasphyxia; Acanthosis nigricans; Pharyngial mycosis; Cutaneous and respiratory troubles by dyed furs; Cutaneous gangrene by arterial embolus; Gangrene of the penis; Author of several articles for the "Encyclopedie Medico-Chirurgicale" (1937).

Kennebec

A meeting of the Kennebec County Medical Association was held in Waterville, Thursday, September 15, 1938.

Clinical Session at 5 P. M. at the Elm City Hospital, which was presided over by Samuel H. Kagan, M. D., President of the Association:

(1) Tuberculosis of the Left Thumb—John G. Towne, M. D.
(2) Ruptured Appendix—Harvey J. Bourassa, M. D.
(3) Sacroiliac Strain—Charles E. Towne, M. D.
(4) Three Cases of Cancer of Cervix Treated with Radiation—Ovide Pomerleau, M. D., and Moses F. Lubell, M. D.
(5) Spinal Meningitis Treated with Sulfanilamide—Ovide Pomerleau, M. D.
(6) Fracture of Pelvix and Ruptured Urethra—A. H. McQuillan, M. D.
(7) Chronic Glomerular Nephritis—T. E. Hardy, M. D.
(8) Nasal Plastics—E. R. Irgens, M. D.

Dinner: 6.30 P. M. at the Elmwood Hotel, followed by a business meeting. Minutes of the last meeting were read and approved. .

Elmer M. Tower, M. D., of Waterville, was admitted to membership by transfer from the York County Medical Society.

Application of Allan Campbell Hurd, M. D., of Gardiner, was received and referred to the Board of Councillors.

Resolutions on the recent death of Forrest H. Badger, M. D., of Winthrop, were read by Dr. Leon D. Herring. *Resolved,* That a copy of the resolutions be spread upon the records of the Kennebec County Medical Association, and that a copy be sent to the bereaved family.

The speaker of the evening was Howard M. Clute, M. D., of Boston, whose subject was "Diagnosis and Management of Acute Inflammations of the Gall Bladder." Dr. Clute in his talk stressed the following facts: First, that obstruction to the cystic duct is the first step of acute cholescystitis causing pressure on the blood vessels and lymphatics with resulting edema and necrosis. Perforation occurs in about 20% of acute cases of cholecystitis. Infection apparently is not a primary factor but secondary to obstruction of the cystic duct. Infection does not necessarily follow as is seen in cases of hydrops without infection. The onset of acute cholescystitis is usually sudden with colicky pains radiating to the right back and shoulder, and sometimes to the left shoulder. The latter, he believes, is due to influence of the pancreas. The patient is usually red-faced, restless and tosses about in bed. Vomiting is usually due to distention of the common duct and not of the gall bladder. Simple gall stone colic rarely causes persistent vomiting. An onset with high fever, chills, and pain means infection usually concurrent with other infections, such as typhoid. In these cases, immediate surgery is not indicated. Treatment: Immediate operation in acute non-infectious obstructive cholescystitis. In infectious type, surgery depends upon question of perforation and peritonitis. The use of glucose solution is very important in cholecystitis.

Dr. Clute's address was very interesting and it was thoroughly enjoyed by everyone. The attendance at this meeting was especially good.

There were 41 members and guests present.

Respectfully submitted,
FREDERICK R. CARTER, M. D.,
Secretary.

Piscataquis

A meeting of the Piscataquis County Medical Association was held at the Mayo Memorial Hospital in Dover-Foxcroft, September 8 at 4.30 P. M.

The application for membership from Burton Sanford Marsh of Greenville was read and referred to the board of censors.

Dr. Ruth Thomas, Chairman of the Committee on Medical Care, reported that she had done nothing as yet. At this time, however, she appointed as the other two members of her committee Dr. Pritham and Dr. Card.

The following officers were elected:

President, H. C. Bundy, Milo.

Vice-President, W. R. L. Hathaway, Milo.

Secretary-Treasurer, N. H. Nickerson, Greenville.

Delegate to the Maine Medical Association 1939 Annual Session, F. J. Pritham, Greenville Junction; Alternate, R. H. Marsh, Guilford.

Board of Censors: Ruth Thomas, M. O. Brown and W. E. MacDougal.

Legislative Committee: W. R. L. Hathaway, G. E. Dore and M. O. Brown.

The next meeting will be held in Milo, November 17th.

Respectfully submitted,
N. H. NICKERSON, *Secretary.*

Somerset

The annual meeting of the Somerset County Medical Society was held at Lakewood Inn on August 26, 1938.

After an excellent dinner at the Inn enjoyed by forty-six members and guests, a program and business meeting was called in the theatre auditorium.

We were fortunate to have with us Dr. Bunker and Dr. Carter, president and secretary respectively, of the Maine Medical Association each of whom spoke briefly but interestingly on topics of interest to us relative to matters concerning our own and the State Society.

The principal speaker of the occasion was Homer W. Smith, A. B., Sc. D., professor of Physiology at New York University, whose subject was Recent Studies in Renal Physiology. This was a very learned and carefully prepared paper, illustrated by lantern slides, but rather profound for the ordinary practitioner, although many new phases of this organ seem to have been discovered.

The business meeting and election of officers followed the program and the following slate of officers and committees was appointed for the ensuing year:—

President, W. H. Walters, Fairfield.

Vice-President, P. E. Gilbert, Madison.

Secretary-Treasurer, M. E. Lord, Skowhegan.

Board of Censors: W. S. Stinchfield, F. P. Ball and H. W. Smith.

Program Committee: R. P. Laney, H. L. Reed and A. J. Stinchfield.

Delegate to the Maine Medical Association 1939 Annual Session, W. H. Walters; Alternate, W. S. Milliken.

One new member was added to our Society, viz: G. E. Sullivan, who was transferred from the Oxford County Society.

The following committee was appointed to study into and direct the members relative to Need and Supply of Medical Care: A. J. Stinchfield of Skowhegan, R. P. Laney of Skowhegan, W. H. Walters of Fairfield, W. S. Milliken of Madison, M. E. Lord of Skowhegan.

MAURICE E. LORD, *Secretary.*

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Notice

To All County Secretaries:

The Cancer Committee of the Maine Medical Association has available for presentation before County Societies a symposium on the different phases of Cancer. It is hoped that County Secretaries will avail themselves of the use of this paper. Whenever possible members of the State Cancer Committee will be glad to attend County meetings and assist in the discussion. Members of the Cancer Committee are F. B. Ames, Bangor, Chairman; E. V. Call, Lewiston; Magnus Ridlon, Bangor; E. H. Risley, Waterville, and William Holt, Portland.

FORREST B. AMES, M. D.,
Chairman Cancer Committee
Maine Medical Association.

Coming Meetings

Kennebec

Kennebec County Medical Society, Frederick R. Carter, Augusta, Secretary.
October 20th, Central Maine Sanatorium, Fairfield, *Dr. Walter Bauer*, speaker.
November 17th, Waterville, *Dr. Louis A. Phaneuf*, speaker.
December 15th, Augusta State Hospital, *Dr. A. Warren Stearns*, speaker.

Oxford

Oxford County Medical Society, J. S. Sturtevant, Dixfield, Secretary.

The annual meeting of the Oxford County Medical Society will be held at the Bethel Inn, Bethel, Maine, Tuesday, October 18th.

Program:

5.00 P. M. Business meeting and election of officers.

6.30 P. M. Dinner.

7.30 P. M. Address by Dr. G. E. Haggart, Lahey Clinic, Boston, Massachusetts. Subject: *Some Problems in Bone and Joint Surgery;* Dealing with Orthopedic Problems the General Practitioner might encounter.

Piscataquis

Piscataquis County Medical Society, N. H. Nickerson, Greenville, Secretary.
November 17th, Milo.

Necrology

Edville Gerhardt Abbott,
1870-1938

Doctor Edville G. Abbott, 68, world-famous orthopedic surgeon, died at his home in Portland, August 27th, from a heart attack.

Doctor Abbott had been in failing health for several weeks but had been attending to his accustomed tasks as usual. He had been in semi-retirement for the past three years.

Doctor Abbott achieved world-wide renown through his research and skill in the prevention and cure of bone deformities, especially in children. His fame brought him patients from all corners of the world. At the invitation of imminent European surgeons, he had lectured to medical groups in several European countries and had received distinguished honors from many.

A native of Hancock, Doctor Abbott was born November 6, 1870, the son of Alonzo and Maria B. Mercer Abbott.

He attended the Eastern Maine Conference Seminary at Bucksport, being graduated in 1889. He then entered the granite business with his father, but five years later entered the Maine Medical School at Bowdoin and received his M. D. in 1898. He continued his studies in Europe, spending a year at the Friedrick Wilhelm Universitat, Berlin, and for shorter periods in London, Paris and Vienna.

On the completion of his medical studies, he established himself in Portland. He was a moving force behind the establishment of the Children's Hospital here and became its first surgeon-in-chief, serving in this capacity for twenty-eight years. For ten years, from 1926 to 1936, he also served as chief orthopedic surgeon at the Maine General Hospital, and as consulting surgeon at Sisters' Hospital, Lewiston, The Webber, Knox County, Augusta City and Rumford Hospitals.

Doctor Abbott had been honored by many colleges and societies, Bowdoin College gave him several honorary degrees; an A. B. degree in 1906, A. M. pro merito in 1908, and Sc. D. in 1914. Colby College honored him with a Doctor of Science degree in 1925 and the University of Maine with a degree of Doctor of Laws last June. He was elected to numerous distinguished medical societies both in America and Europe.

He was a member of the Maine Medical Association, a Fellow of the American College of Surgeons, a member of the National Institute of Social Sciences and the American Academy of Political and Social Science. He had written a number of medical treatises and was a contributor to medical journals.

It is safe to assume that the establishment and operation of a charitable institution, such as The Children's Hospital, is a great accomplishment in the life of anyone. In his textbook on Orthopedic Surgery, Dr. Royal Whitman says, "One may conclude that the principle on which the Abbott treatment is based is correct, and that the method is mechanically the most effective means of correcting lateral curvature of the spine," which, coming from a recognized authority, speaks much for the Abbott treatment of scoliosis.

All things considered, Doctor Abbott was the foremost medical man in Maine in his day and generation.

Book Reviews

"New and Non-Official Remedies"

Containing Descriptions of the Articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1938. Published by the American Medical Association, Chicago, Ill., 1938.

In this volume of 590 pages are listed and described medicinal articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on the date of January 1, 1938. The descriptions of these articles are based on investigations made by and for the Council, or on information supplied by the manufacturers thereof. In this year's edition a large amount of valuable information is presented on the Anesthetics; the Barbital Compounds; the Digitalis Preparations; Serum and Vaccines; and the Vitamin Preparations.

New and Non-official Remedies has been in the past a very valuable and reliable guide for physicians in regard to authoritative knowledge of the newer remedies produced to relieve human suffering. This year's edition again is filled with such data as the general practitioner will need in readily accessible form as presented only in this book, whenever he prescribes any of the newer medicinal agents. This service of the Council is of almost inestimable value to the medical profession.

"Medical Writing—The Technic and the Art"

By Morris Fishbein, M. D., Editor *The Journal of the American Medical Association*, Chicago, with the assistance of Jewel F. Whelan, Assistant to the Editor. Published by the American Medical Association, Chicago, 1938.

With "Medical Writing" the medical profession of the English writing medical world is presented with an authoritative guide for the production of medical literature of superior quality. Attentive reading of this 212-page book, which is dedicated to Dr. George H. Simons, will convince the reader that every writer on medical subjects will find a great deal of helpful information which is based on present-day standards in use by the American Medical Association Press.

The book is divided into sixteen chapters entitled: An Acceptable Paper; Style; The Subject and the Material; Construction of the Manuscript; Words and Phrases; Spelling; Capitalization; Abbreviations; Numbers; Pharmaceutic Products and Prescriptions; Bibliographic Material; Preparation of the Manuscript; Illustrations; Charts and Tables; Revision; and Proofreading. There is a large supplement which contains abbreviations of names of medical and allied periodicals of many countries.

It seems that every writer of speeches or papers for his county medical society or of articles for his State and National Journals, etc., would wish to include "Medical Writing" in his library and refer to it frequently as a reliable guide to a more beautiful and stylishly correct American medical language.

"Psychotherapy"

By Paul Schilder, M. D., Ph. D., Clinical Director, Bellevue Hospital, Psychiatric Division; Research Professor of Psychiatry, New York University Medical College. Published by W. W. Norton & Co., Inc., New York, 1938. Price,, $3.50.

"Psychotherapy" was created by the author as a result of his conviction that this form of medical therapeusis can be taught not only as an art but as a technical procedure which is based upon scientific principles. This teaching is based upon the concept that man as an individual suffers as a complete person, not only from his being what he is, but also from his being thus and so while living in an environment not of his making, which changes almost constantly and forces him into active attempts to adjust himself as quickly as possible to it. The conflicts arising from this ever-present necessity for readjustment tends to produce various forms of response behavior. Only the properly trained physician will be able to discover recent or remote causes for such suffering as is connected with these behavior changes and devise appropriate methods of treatment. The author stresses the point that only such phychotherapeutic methods can be successful which are based upon the knowledge of the reality of man's conflicts and of man's various efforts at adjustment satisfying either to himself or to his group. He presents here a form of textbook written for the physician who wishes to apply scientifically correct psychotherapeutic methods of treatment for the ever-increasing number of sufferers from various forms of neuroses, behavior and character difficulties, as well as those who suffer from social and ideologic conflicts of various types.

The book is divided into eleven chapters, entitled: Some General Principles; Psychophysiological Relations; The Symptomatology of Organic Disease from the Point of View of Psychology; The Symptomatology of Mental Suffering; Symtoms which make others Suffer; Somatic Health as an Experience; Psychic Health as an Experience; Technical Tools of Psychotherapy; The Relation between Physician and Patient; The Psychotherapeutic Systems; The Treatment of Specific Types of Neuroses, Psychopathies, and Psychoses.

In the opinion of this reviewer, the most important contributions published by the author are his introduction to the analyses of Ideologies and of Social Adaptations and his remarkable elaboration of his own method of Group Psychotherapy. It seems that here at last we are introduced to a practicable and scientifically correct method of psychotherapy which is applicable to several patients at one time, thus making psychoanalytical treatment of the neuroses possible for a greater number of patients at an appreciable reduction in cost. The author is in the favorable position to be able to point to the successful application of his group-therapeutic methods of treatment of mental sufferers as practiced by him in a large measure at the Bellevue Hospital, Psychiatric Division.

Dr. Schilder's "Psychotherapy" deserves a place in every practicing physician's library. It will help to broaden the physician's own world of activity and provide him with a guide for his efforts at helping human beings to fulfill their destinies better in a spiritually richer world.

PROCEEDINGS

at the

EIGHTY-SIXTH ANNUAL SESSION

of the

MAINE MEDICAL ASSOCIATION

held at

THE MALVERN, BAR HARBOR, MAINE

JUNE 26, 27, 28, 1938

FIRST MEETING

of the

HOUSE OF DELEGATES

The First Meeting of the House of Delegates of the Maine Medical Association was held at the Malvern Hotel, Bar Harbor, Maine, on Sunday afternoon, June 26, 1938, at four-thirty o'clock in the afternoon, with Dr. Willard H. Bunker presiding.

Chairman Bunker: The meeting will please come to order, Ladies and Gentlemen.

This is my first appearance before so many strangers and I hope you will pardon any errors or omissions that I may make.

I have one request to make; that we confine our remarks to the questions under discussion, and avoid, as far as possible, all long orations.

The first order of business is the roll call by the Secretary.

Dr. Carter then called the roll and the following members responded:

For Androscoggin County, Dr. W. L. Haskell of Lewiston, Dr. A. W. Plummer of Lisbon Falls and Dr. W. E. Webber of Lewiston.

For Cumberland County, Dr. E. R. Blaisdell of Portland, Dr. Langdon T. Thaxter of Portland, Dr. Ralph A. Getchell of Portland, Dr. Luther A. Brown of Portland, Dr. William D. Anderson of Portland, Dr. J. C. Oram of South Portland.

For Franklin County, M. R. Colley of Wilton, Alternate.

For Kennebec County, Howard F. Hill of Waterville.

For Knox County, William A. Ellingwood of Rockland.

For Oxford County, R. R. Tibbetts of Bethel.

For Penobscot County, F. B. Ames of Bangor, H. C. Scribner of Bangor, H. C. Knowlton of Bangor and H. E. Thompson of Bangor, and L. H. Smith of Winterport.

For Piscataquis County, F. J. Pritham of Greenville Junction.

For Sagadahoc County, A. F. Williams of Augusta.

For Somerset County, E. D. Humphreys of Jackman.

For Waldo County, Foster C. Small of Belfast.

For Washington County, D. F. Bennett of Lubec.

For York County, Stephen Cobb, Sanford, and C. W. Kinghorn, Kittery.

Chairman Bunker: It is necessary that we have ten members present, in order to constitute a quorum; we have twenty-three members present, so I think that we can proceed with our business.

The next order of business is the appointment of a Reference Committee by the Chair. Therefore, I have appointed H. E. Thompson of Bangor as Chairman, E. R. Blaisdell of Portland and W. L. Haskell of Lewiston. Incidentally, this Committee will meet anywhere the Chairman designates; they will meet sometime before the second meeting of this House of Delegates, and they will answer any questions they can.

The next order of business is the appointment of the Nominating Committee. This requires one delegate from each councilor district. I have appointed C. H. Jamison of Rockland, J. C. Oram of Portland, W. E. Webber of Lewiston, E. D. Humphreys of Jackman, D. F. Bennett of Lubec and Forrest B. Ames of Bangor.

At this time, we are going to listen to the report of the Chairman of the Council, Dr. T. A. Foster of Portland.

Dr. T. A. Foster: First of all, I want to congratulate Cumberland County, because we have here today, all the way from Portland, five out of the six members of the House of Delegates present. I think that is fine. [Applause.]

[Dr. Foster then read his report as Chairman of the Council.]

Chairman Bunker: You have heard the report of Dr. Foster, Gentlemen, as Chairman of the Council. What is the pleasure of the assembly?

A Member: I move that this report be accepted.

This motion was duly seconded by several of the members present, and was carried.

A Member: Will this be referred to the Reference Committee, or will it automatically go there? I mean this Committee that you appointed a few moments ago.

Chairman Bunker: I don't believe that is necessary, Doctor.

We shall now listen to the presentation of the budget by Dr. T. A. Foster, Chairman of the Council.

Dr. T. A. Foster: As Chairman of the Council, I take this opportunity to present the budget for 1938 and 1939.

President's expenses in attending meetings of each County Society, $300.

Salary of the Secretary-Treasurer, $1,000.

Office Expenses of the Secretary-Treasurer, $200.

Salary of the Assistant Secretary, $1,500.

Office expenses in Portland, $600.

Medical Advisory Committee, $500.

Other Committees, $200.

State Delegates and Council, $200.

Delegate to the A. M. A. meeting, $250.

Expenses of Annual Meeting, $200.

Publicity Committee, $100.

Journal expenses; Editor, $1,000; appropriation to Journal Expenses, $1,000.

Annual Fall Clinical Session, $200.

The total of the budget is $7,350.

A Member: I move that the budget, as read, be accepted.

This motion was duly seconded by several of the members present.

Chairman Bunker: All those in favor of the motion will please signify by raising the right hand. Contrary minded? *It is* a unanimous vote.

Chairman Bunker: Next, we are going to listen to the reports of the delegates. First, I am going to call upon Dr. William A. Ellingwood of Rockland, for his report as Delegate to the American Medical Association. [Applause.]

Dr. Ellingwood: If you will allow me to defer this until tomorrow's session of the House of Delegates, I shall appreciate it very much. I have had a very short time to prepare anything, as I just returned home.

Chairman Bunker: That is perfectly agreeable to us.

Dr. Plummer: In regard to the acceptance of that previous report, Mr. Chairman, as I recall it, there is one thing in there in regard to rescinding the vote passed last year as to a basic science law. Now, I would suppose that a thing of that kind would go to a Committee on Reference for consideration, and then be reported back. I wouldn't dare to say that that is true, but it almost seems to be so. There are no other matters in there that occur to me right now.

CHAIRMAN BUNKER: I might say, Doctor, that the House of Delegates accepted the report, and we might ask them a little bit later if they wish to rescind that.

We shall now listen to Dr. Charles Kinghorn of Kittery, our Delegate to the New Hampshire Medical Society, which met on May 17 and 18 at Manchester, New Hampshire.

DR. CHARLES KINGHORN: I had the most exciting game of golf I ever played. [Laughter.] I attended part of the sessions of both days, and they had a very interesting program. They are now running the conference system, the same as we have it. They have four conferences each morning, and the scientific sessions in the afternoon.

I did not get to the banquet and I also did not get to the session where the delegates were introduced, but I took in most of the other sessions.

I also advertised our meeting today so that we might have some delegates here. I hope that we will be able to entertain them so that they will send their delegates every year. Three years ago, I was a little bit criticised that we weren't properly entertaining our delegates. I thought by the criticism I heard that when I became a delegate, they would meet me at the train with a band and take me up to the room and serve me with some refreshments. But I wasn't met by any band or anybody else; however, knowing so many of the doctors in Manchester, I was successful in getting my refreshments and plenty of entertainment.

I think that is all I have to say. [Applause.]

DR. FOSTER: May I ask Dr. Kinghorn a question? Do they have their meetings at a resort or at a clinical center?

DR. KINGHORN: In New Hampshire, they hold all of their state meetings at a hotel in Manchester. The facilities for holding the meeting are very poor; that is, the hotel auditorium has very poor accoustics; you can hear very little in the back of the room, unless they are working the loud speaker, and half the time, the speaker doesn't get near enough to the loud speaker so that you can hear much in the back of the auditorium. The exhibits are off from the auditorium, in the lobby, and there is too much noise there all the time. However, they do stick to Manchester for their meeting place.

They do not have any other sessions during the year, except the New Hampshire Surgical Club; they usually hold a meeting in one of the centers, like Nashua, Concord, Manchester or Portsmouth; then they hold a summer meeting at a summer resort, or up in the mountains somewhere.

CHAIRMAN BUNKER: Gentlemen, you have heard Dr. Kinghorn's report. What is your pleasure?

DR. PLUMMER: I move that the report of Dr. Kinghorn be accepted.

This motion was duly seconded by several of the members present, and was carried.

CHAIRMAN BUNKER: The next report is that of Dr. Hardy of Waterville, as Delegate to the Massachusetts Medical Society. Is Dr. Hardy present?

DR. KINGHORN: I left Dr. Hardy at the Thayer Hospital, taking care of one of my fellow legionnaires. I imagine he is still there.

CHAIRMAN BUNKER: The next report was to have been from Dr. Jameson, but I do not see him here, and incidentally, he was not able to go as delegate, and therefore, he will have no report.

I have a brief report here, as Delegate to the Vermont Medical Society.

Members of the Maine Medical Association and Distinguished Guests:

I hereby submit a brief report on my official visitation as a delegate from Maine to the Annual Meeting of the Vermont State Medical Society held at St. Johnsbury, Vermont, October 14th and 15th, 1937.

After a day's ride through the beautiful hills of Vermont covered with foliage as you would expect in October, Mrs. Bunker and myself arrived at St. Johnsbury on the evening of October 13th. We were received by President and Mrs. William G. Ricker and were given a fine room at the St. Johnsbury hotel.

After a sumptuous dinner, I attended the first meeting of the House of Delegates and was favorably impressed with the manner in which their business was conducted.

The following forenoon I attended the first session held in the State Armory and listened to many important papers with their usual discussion, one of which made an outstanding and lasting impression. This was a paper by Walter Schiller from Vienna, Austria. The title was *Early Diagnosis of Cancer of the Cervix.*

The President's Address on *Modern Medicine as Exemplified by Hippocrates,* was a masterpiece, my only regret being that it was my duty to discuss this paper.

Dr. R. J. Leland of Chicago, in his usual able manner, read a paper entitled *A Challenge to Medicine.*

The same afternoon was devoted to Motion Pictures on Syphilis and the Annual Banquet, which was an elaborate affair, was held that evening. The Chairman was Frank E. Farmer, St. Johnsbury, Vermont.

The following forenoon was devoted to the second meeting of the House of Delegates, followed later by a general assembly with many interesting papers and their usual discussion.

I returned home with a feeling of gratitude toward the officers and members of the Vermont Medical Society and am anxiously waiting for an excuse to visit their society again in the near future.

CHAIRMAN BUNKER: Next, there will be a report from the Standing Committees. The first is the Scientific Committee. Is Dr. John O. Piper of Waterville here? He is not here. Dr. Cobb, can you give us a report on that?

DR. COBB: I will get Dr. Piper, if you want me to.

CHAIRMAN BUNKER: Will you please do that.

The next report is that of the Committee on Social Hygiene. Is Dr. E. S. Merrill of Bangor here?

[There was no answer.]

Then we shall hear from Dr. E. W. Gehring. I might say that there is really nothing to report on the Publicity Committee. In that case, we can now take up the reports of the special committees.

I do not believe that Dr. George Young is here; he was to report for the Tuberculosis Committee.

Dr. Gehring is not here, either; he was going to report for the Committee on Investigation of Collection Agencies.

DR. FOSTER: Dr. Gehring told me to report that nobody had sent in any requests to investigate any collection agencies, so that he had no report to make.

CHAIRMAN BUNKER: Thank you, Doctor. The

next report we shall hear will be the report of the Committee on Problems of Health Insurance and State Medicine, by Dr. W. E. Kershner of Bath.

Dr. W. E. Kershner: Mr. Chairman and Gentlemen, the Committee has nothing further to report following last year's report. The Committee was continued because of the general, unsettled conditions regarding bills in the several states and Congress on changing the set-up of medical practice, and there hasn't been anything to filter through that would give us any opportunity to go to work.

The Chairman of the Committee feels, at the present time, that that Committee had better be united with the Graduate Education Committee, because it seems, from all he is able to learn from the literature, and so forth, that a great deal of this medical change is due to those few of the medical profession who do not take an interest in scientific medicine or make any effort to keep up.

There have been quite a number of articles of importance on this subject, but one of the last of these, in the *Journal of the A. M. A.*, very precisely calls attention to the ideals of the medical profession, and questions what any possible change will do to those ideals.

It seems to me that if we could reduce our Committees by one, by uniting this Committee with the Graduate Education Committee, we should do so.

We have in this State, and this intimately interests us, about three hundred men who are in organized medicine, or apparently in medicine. A few years ago, through the wisdom of the Council, they instituted a Clinical Session, hoping that those who felt as though they didn't get anything out of set papers would attend such a meeting. But the same group who come here year after year go to the Clinical Sessions, so that there is apparently something that we are unable to put across that will bring out the men who have not habitually attended. What the answer to that question is, I don't know. I think that the Clinical Sessions have been very interesting, and very successful, but they have been interesting and successful to those who always go, and to those who go to the Annual Meetings as well.

However, I am thoroughly convinced in my own mind that the change in medical practice forced upon us from above, call it regimentation or call it what you please, will depend to a great extent upon how we progress in medicine itself. We can't get rid of the fact that we are subject to criticism, as a body, and while I appreciate that this is no place to preach to those who always attend because the preaching doesn't get through to those fellows who don't attend, I can't help but say this just the same. How we can get an evangelist around to the group who doesn't take any interest in medical matters is beyond me.

Chairman Bunker: Do you wish to make your suggestion about this Committee in the form of a motion?

Dr. Kershner: I would not at this time; perhaps a little later, when you appoint the special committees, I might have something to say then.

Chairman Bunker: I shall call that a report, Doctor, and I shall ask that it be accepted.

Dr. Plummer: I move that the report of Dr. Kershner be accepted.

This motion was duly seconded by several of the members present, and was carried.

Chairman Bunker: Dr. Piper, I would like to ask you to give your report on the Scientific Committee, please.

Dr. Piper: I don't know as there is any other report to make. You will have to look at the program to see the report of our Committee. One of the guest speakers is already here and another one is coming Tuesday; the others, I haven't heard just when they are coming. I haven't heard of any who are not coming.

However, there is one Conference that I know of, where a man will not be able to be here. Dr. Cutler cannot be here, so we shall not have the Conference on Geriatrics.

Chairman Bunker: Thank you very much, Dr. Piper.

Will someone make a motion that Dr. Piper's report be accepted?

A Member: I move that this report be accepted and placed on file.

This motion was duly seconded by several of the members present and was carried.

Chairman Bunker: Is Dr. Roland Moore in the hall?

Dr. Foster: He isn't coming down.

Chairman Bunker: His report was to have been on the Committee for Maternal Welfare.

I might say that I am going through this part of our session as rapidly as possible because we have a lot of business to discuss today.

I might mention, while we are waiting for Dr. Wakefield, that the report by Dr. B. L. Bryant, on the Training School for Nursing Attendants was published in the May issue of the Journal, so that it will not be necessary to have that report read.

Now, Dr. Wakefield, with your permission, we should like to have the report of the Legislative Committee.

Dr. Wakefield: Mr. Chairman and Delegates. As Chairman of the Legislative Committee, I thought you should have a little explanation of what happened in the council meetings. Dr. Foster has reported for the council meetings.

You will remember that you adopted Dr. Kershner's recommendation a year ago, that a basic science law be sent to the next Legislature, and that we appropriate money for the expenses of the same.

As I began to travel over the State last summer and during the fall and winter, I took this up with the various county societies, and I soon found that there was a great difference of opinion about what we should do at the next Legislative Session. Some thought we should have a basic science law, and some thought that we should let the present law alone. As I looked at the thing in various sections of the State, I found hardly a man agreed as to what should be done. I thought that this question was so far-reaching and so important that it wouldn't be advisable, perhaps, for three men of the Legislative Committee to make a recommendation to you. I thought a larger section of the State should be represented.

Therefore, I obtained permission from the council to enlarge the Legislative Committee, which I did, and Dr. Foster has read you the names of that Committee; it is a representative Committee of all the sections of the State of key men who are particularly interested in Legislative matters.

On April 23rd, we met in Augusta; all of the Committee members weren't there, but a majority were there, at least the ones who were interested, and we spent a long time discussing the subject.

I shall not detail the discussion, as that is not necessary, but after we talked two or three hours and got the opinions of the various ones on the proposals, Dr. Hill, Ex-President, of Waterville, made this resolution, which was unanimously adopted.

"The Legislative Committee, in session on April 23, 1938, voted, that the following recommendation be made to the House of Delegates at the 1938 Annual Session: That this Committee or a similar Committee be continued through the legislative year; that said committee watch all legislative matters which might be of interest to the members of the profession, ... and that said Committee be empowered to act."

In other words, it was the concensus of opinion of that Committee, after a long discussion, that we had better let things go as they are, and not introduce any legislation, but that we should watch what we have. It was the opinion of many of the members of this Committee that if we kept things as good as they are now, we would be doing well.

That is the recommendation that we have to make to this body. I thank you. [Applause.]

Chairman Bunker: Gentlemen, you have heard the report of the Legislative Committee, by Dr. Wakefield. What is your wish?

A Member: I move that this report be accepted.

Question: Before we accept that report, I want to ask a question. The acceptance of the report doesn't necessarily mean the acceptance of the recommendation, does it?

Chairman Bunker: No.

This motion was then duly seconded by several of the members present and was carried.

Chairman Bunker: At this time, following the report of the Legislative Committee, it might be advisable to consider the question of rescinding the recommendation made last year; this was approved by the body at Belgrade Lakes on June 21, 1937, at the Annual Session. At this time, I might call upon Dr. Kershner, who, I think, could explain in a little more detail why we would like to have that vote rescinded.

Dr. Kershner: Mr. Chairman and Delegates, I was appointed Chairman of the Reference Committee, and that was a part of the Reference Committee work. Several men, who were interested in that sort of thing, appeared before the Reference Committee, and if I remember right, the recommendation was that if they wanted a vote, that was the thing to do. It could be done, the Committee believed, under certain definite conditions, and the conditions were laid down. The appropriation was made, with further remuneration if the bill passed. This was really sponsored by several members of the Association and not the Reference Committee, as it was not their child.

It seems to me that that can be well handled by one of the delegates making a motion that that action be rescinded and that Dr. Wakefield's recommendation, on behalf of his Committee, be adopted. I am not a delegate, so I cannot do that.

A Member: I move that this matter be rescinded and that the recommendation of the Legislative Committee be adopted.

This motion was duly seconded.

Chairman Bunker: Is there any discussion?

Dr. Plummer: Mr. Chairman, it would be well to table the other matter pending discussion of this, and pending the passage of this motion. There is already a motion, as I recall it, to accept the report of the Legislative Committee; that motion should be before the House unless we dispose of it in some way. I, therefore, move that we table the motion to accept the report of the Legislative Committee, pending the action on this motion.

Chairman Bunker: I think the motion to accept it has already been voted upon, Doctor.

The question now is whether we shall vote on rescinding that last ruling.

Dr. Knowlton: I have been interested in this basic science change for about a year and a half. I know, full well, that there are other issues that would incude whether or not we should work for the passage of a basic science act. The hospitals of the State, and most of us, are interested in this bill. We are informed that it would be difficult to get too much out of the Legislature, if we get anything at all.

However, the Osteopaths are legally with us, and on nearly a common footing. They cause us a great deal of distress. Three or four doctors can't get together without vocally distressing themselves because of the presence of the osteopaths and the work they have done.

Since I have been a member of the Association it has been our legislative policy to chase along with whatever legislation was proposed and to kick against them, and we have gotten exactly nowhere. And it is my impression that that is where we will continue to get. I can merely quote Dr. Wakefield, from his report, to that effect, that well, if the osteopaths want full appointments, we may not be able to head this off.

Now, it seems to me that in our appointed positions, as guardians of the public health, that is the one thing that we must not lose sight of. In other words, if the osteopath is to be legally put on a common footing with us, then he may or may not legally practice medicine. Now, that is the hold back that they have, that we should try to see to it that they are as well educated as we are; eventually, they will be accepted as one of us, when their education becomes good enough.

Having been interested in this matter, last winter I wrote the A. M. A. in Chicago, and I got a letter from Dr. Woodbury. Parts of that letter, I should like to read.

He first speaks of the osteopaths with reference to their status, from the revised sections.

[Dr. Knowlton then quoted from Dr. Woodbury's letter.]

Now, just what that examination in surgery is, I do not know; they are not authorized to practice surgery and obstetrics; yet they may use such drugs as they need in the practice of those arts.

The scope of osteopathy was, I believe, broadened sometime ago, so as to authorize licentiates to practice surgery and obstetrics, according to my information. This was enacted without organized medicine having anything to do with it. It was thought that the osteopaths would defeat any privileges they had, but these privileges cannot be taken away from them at this late date.

Now, I had something to do with hastening the demise of this bill; it was a basic science law or bill in name only.

I believe, however, that the enactment of a true basic science law in Maine would materially aid in keeping future incompetents out of the State.

We have, in this country, several states which have basic science laws; Wisconsin has such a law, Arizona, Arkansas, Connecticut, District of Columbia, Iowa, Minnesota, Nebraska, Oregon, Washington, also have such laws.

Now, I don't believe that passage of such a bill, if it is possible and it may not be, is going to immediately clear the air. It is, however, going to stop us from being associated with these men of inferior training. It will head toward the day when our people will be quite generally better treated.

I really do deplore the attitude of the Legislative Committee, to simply chase along. I should like to speak against the rescinding of last year's motion, and the adoption of the present Committee.

Chairman Bunker: Gentlemen, you have heard the remarks made by Dr. Knowlton. Is there any further discussion on this matter?

Dr. Plummer: Mr. Chairman and Gentlemen. I am inclined to agree with Dr. Knowlton to some extent. I think that we are to blame for the situation that we are in. While I have, on several occasions, reviewed somewhat the history of this matter, with which I think I will say I am reasonably familiar, and I think, as I say, that we are to blame for the situation that we are in.

This matter has been brought to the attention of this House of Delegates before, and many of you have been here a good many times, the same as I have.

As long ago as twenty to twenty-five years ago, there was introduced into the Legislative Halls here to quite an extent, what amounted to a basic science bill, before there were any osteopathic or chiropractic bills for presentation or passage. That bill proposed to amend the Examining Act at that time existing, by striking from it practically all reference to the treatment of disease and the use of drugs or the knowledge of drugs, except insofar as they might be poisons, and merely to require that one shall have a day before the Board, to show their understanding of the human body, its formation and the functions of its various parts, it physiology, of course, and its pathology in disease, and something, of course, of surgery, to ascertain that the evidence is understood with relation to the human body in health and disease. After that examination, and when a man comes to practice, he practices whatever method of treatment he sees fit. Now, that bill, at that time, and to my certain knowledge, was opposed by the Examining Board and it was opposed by the profession as a whole.

Now, ten years ago, when there were probably fifty or sixty osteopaths in the State, an attempt was made to get together on a bill which would be satisfactory to us and to them. A bill was drawn up by a Committee which was appointed at that time, and it was, as I have reason to think, satisfactory to the attorney for the osteopaths and to the attorney for the society. And, the society turned it down!

Now, what is the situation as it exists, with regard to a basic science law? The osteopaths, the chiropractors are the self-assumed guardians of the public health.

They all start in with the basic science examination; after that, the osteopath starts off in one direction as to examination, the chiropractor starts off in another direction, and the regular physicians, so-called, start off in still another direction. According to the law or the combination of law, we are merely a section, with the other fellows, then each going in a different section and being examined in four or five subjects.

Now, if we can take those subjects and let everybody be examined in them, and then after that, don't examine anybody in anything, then we are all together, at least. Then, whether or not, as a medical society, we shall accept as members, those who are graduates of certain schools that we do not recognize, that is another question.

But to declare ourselves merely as a sect of medicine, which, as I say, is what we are doing, I don't agree with that. I don't belong to any sect, as least I hope not.

As a friend of mine once said: "The osteopaths, the homeopaths, the allopaths and a lot of them, are paths of glory, which lead but to the grave." I don't want any "path."

So far as I am concerned, I am willing to say this, and I think it is probably true of any man here. If I go to a patient and I think that osteopathic treatment or whatever it may be, is necessary, that patient can have it and there isn't a one of us here but who would not utilize all the forces at his command.

If we are going to have a basic science law, let us do it by cutting from our examination any reference to the treatment of disease. There may be other things that we should cut. Just let us all bring in the men who answer the questions about medicine, and they will have a legal privilege to practice medicine here in this State.

As I say, if we are to have a basic science law, let it be really science depicted as far as we know, because at the present time, with the exception of comparatively few remedies, we have no scientific remedy for disease.

You and I, or three or four of us get in here occasionally, and one man thinks a certain drug is good, and another man thinks another one is good.

Let us leave out a consideration of the treatment of disease. That is all the difference between the osteopaths and ourselves, as far as that is concerned, anyway.

Chairman Bunker: Gentlemen, are there any further remarks or discussion? If not, are you ready for the question?

A Member: What is the question?

Chairman Bunker: The question is whether this House of Delegates will vote to rescind the vote made by them at the previous meeting, and allow us to carry on the program as outlined by Dr. Wakefield. In other words, to hold what we have. We don't expect to put the osteopath out, because he is already in, but we would like to hold what we have. I will say for the benefit of the members here that it was the unanimous opinion of the members of the Legislative Committee that the basic science law was inadequate at this time, and we didn't wish to instill into the Legislature anything that we couldn't finish this year, but we did want to watch our steps carefully, and see that nothing new was presented to the Legislature by them, which couldn't be cared for by us.

Now, the question is, whether you, as members of the House of Delegates, are willing to rescind the vote made by you at a previous meeting of the House of Delegates, which simply allows us to go on, as outlined by President Wakefield.

Dr. Foster: May I say a word here? If the delegates decide not to rescind the vote made by the last House of Delegates, I understand that then the Association is committed to the vote passed in 1937, to engage an attorney to draw a basic science law, upon which there isn't much general agreement as to the character and the type of the law, and to encourage him to pass that law through the next Legislature and pay him $3,000, if the law is passed. That is, if the rescinding of the vote is not accepted, the Association is committed to the other program.

Chairman Bunker: That is correct.

Dr. Knowlton: There is unanimity of opinion as to what a basic science law should consist of. I have a copy of such graphs embodying the features that should be included.

Dr. Foster: Perhaps I didn't make my point clear. I meant there was no unanimity of opinion among the members of the Association as to what a basic science law was. My point is this. Would it be wise to have a Committee, let us say, report as to what a basic science law professes to do, and how it proposes to do it, before the Committee decides to pass upon it.

Dr. Bliss: I wish to call the attention of the House of Delegates to the fact that this sample bill, of which Dr. Knowlton speaks, furnished by the American Medical Association, was furnished the attorney who drew up the ill-fated basic science law of two years ago. I wish, also, to call your attention to the fact that at the time he drew up the bill, he was furnished not only this sample bill, but also copies of the bill which is now in force in Connecticut, Minnesota, Nebraska, and one other State. He had all of these sample bills, and out of all of them evolved the basic science law which was presented before the Committee, and which came to grief, finally.

Dr. Knowlton: I asked for a copy of that bill as presented. That bill had two or three flaws in it that were quite outstanding. It stated that the applicant had to be seventeen or eighteen. Now, that seventeen or eighteen clause drew more or less mirth, and in the absence of its acceptation, it drew downright competition, and you all know what I mean.

Dr. Kinghorn: I might say that was the thing that our representatives in the legislature objected to, and they would not vote for it. One man told me that he would never vote for that kind of a bill, which would stir up the religious question in the medical profession. He said the bill should be re-vamped.

A great many men will pay from $25.00 to $150.00 to join the country club and play golf, and you just go out and try to get $5.00 out of him for a medical matter, and you are going some. We had two or three men go out of our society, when the fees went up to $10.00; they have joined other societies and have paid $50.00, $75.00 and $100.00. But they wouldn't put anything into medicine.

If we would do what the Committee recommends, we might as well let them come in and sit down and run our offices for us.

Dr. Bliss: Mr. Chairman, I again wish to call the attention of the delegates to the incontrovertable fact, brought out by the Legislative Committee, that those who have been called leaders in their profession in this State are against a basic science law, and they are against a revision of the medical practice act. Now, you cannot go before the Legislature only half supported. You must go before the Legislature as a solid organization, because getting a basic science law through the Maine State Legislature involves the presentation to that Legislature of at least one hundred names of citizens of Maine, requesting the passage of that law. To get these names, it would be a fairly easy thing if every medical man in Maine were interested enough to obtain the signatures. But, to get one hundred names when only a third of us are interested, is quite another thing. It just can't be done. We interviewed, before the Legislative Committee enough of the leaders of the profession in Maine to prove that we do not have and will not have and cannot have unanimous support or anywhere near it. In fact, I doubt if you can get a majority support. Many of the leaders of the profession in Maine, and the people who attend our clinical sessions and our annual sessions, are either lukewarm to any pressure which restricts fewer regular practitioners, or are absolutely opposed to it. There is no use, in our experience, to go to the Maine Legislature unless you have a solid organized body behind you; you do not have such a body. And so, it is proposed that this basic science proposition be dropped for absolute lack of support. But, if any of you think that you can enlist the support of even the leaders of the law in your basic science law or the medical practice act, you are mistaken. You can't support it enough to get it through.

You may go before the Legislative Committee with a perfect bill, and a perfect basic science law, but you can't get it through until you have absolute support from those of us who want it. Such support is lacking.

Dr. Plummer: I would like to say one word, and then I'll try to keep still. Our bill now, and the bill under which we are examined now, is a basic science bill, except insofar as it relates to the treatment of disease. If you wipe that off, you have an examination in anatomy and physiology and the rest of it, I don't know just what, but those are all sciences. It is a basic science bill if you wipe out the stuff that is debatable; science, the thing ascertained as a scientific fact, is no longer debatable; it isn't known to be scientific, otherwise. We know how many bones there are in the body, at one time or another; we know the function of the carotid gland. We know the chemical reaction of certain things taken into the body. Those are scientific facts.

In the present state of our knowledge, with the exception of a comparatively few things, I would say that if we can wipe out what is debatable, then we will have a basic science bill anyhow. What we need is not a new law, but a repeal of the five-year old one.

Chairman Bunker: Gentlemen, this is an important issue and the question is going to be disposed of today one way or the other. You can move anything you please. Personally, I have a lot of respect for the opinions of twelve of the leading practitioners in the State of Maine, and before we inject too much criticism into the Society, I think we should consider it very carefully.

Dr. Ellingwood: I will make a motion, on what has been said concerning this resolution or report, that it be held in abeyance for the time being at least. I think this is a very effective question.

Dr. Kinghorn: There's a difference of opinion there. I have got to disagree with the doctor who spoke previously. I can't disagree on the leading physicians, because I don't know who they are. We have no leaders in our county; we weren't represented. I will put up a wager that I can go out and get ninety per cent of the physicians in York County to endorse a bill. I will put my time against their money, and I will back down on it if I can't do it.

Dr. Blaisdell: I would like to ask Dr. Knowlton if he has any figures to show how large a percentage of the doctors come under the basic science law for the past examination. It strikes me that they may be able to get by with this thing or just a part of it.

Dr. Knowlton: I haven't any figures. And, from that point of view, it doesn't seem to me that it would make any difference. A man can call himself a horse doctor, and yet he may treat anyone. He can call himself a hoodlum. What I am interested in is seeing that he has sufficient knowledge to be able to treat people. You can't pick on the cholecystectomies and the appendices; I don't think we can get at it in quite that way. The "isms" are and always have been present. I want to be sure that the men who are going to treat people, whether they rub backs, pull legs or what, shall be exclusively trained and be able to carry on their treatment. Supposing they are on a hospital staff! It won't make any difference. They should be well trained.

Dr. Bliss: It is well to remember that any bill, whether it is basic science or otherwise, is not retroactive and that there were 201 or 202 osteopaths practicing in the State the last I knew about them, and that there are probably 250 now. With the restrictions placed upon them by the law now, they do not practice surgery and obstetrics, and they only give such drugs as are applicable to the cases they treat. Dr. Blaisdell brought out a very interesting point, when he brought up whether or not they were passing successfully the basic requirements of other states. They are. So that the enactment of the basic science law, in the main, means that we are to improve the quality of the practice of medicine.

Dr. Knowlton: Then what more do you want?

A Member: I would like to eliminate them.

Dr. Knowlton: You can't do it.

Dr. Blaisdell: Of course you can't. That is the trouble. Those are the difficulties. The history of Maine in days gone by, in her relation to the irregular practitioner, has no bearing on the present case. It is interesting, as all things are, but you can't back it out, you know; you can't go back and consider the thing as if it had never happened. Whatever struggles went on in the past, they have nothing to do with the present or the future. We have the osteopath here; he is practicing medicine and he is going to continue to practice medicine, and there are more than 200 who are going to practice medicine. They are all young men, and they are going to be with us for thirty, forty or fifty years. So that any law which you enact now has nothing to do with them. They are here. I say that if York County can produce ninety per cent support for any kind of a law, they are extraordinary and it is an extraordinary county, and can't be duplicated in the State. A man who does outstanding surgery in a large city in Maine made the report before our hearing that he was not interested in where the patient came from; he was only interested in the patient, no matter who referred him or brought him into the hospital; it was his duty to operate upon him and then he was to return the patient to the person in whose care the patient was. There must be many others upon whom you can't count, if you can't count upon men like that.

As you know, the osteopaths are referring more cases than ever we did, and the men who are receiving them are not too anxious to see the osteopaths wiped out.

Dr. Plummer: I ask the gentleman if we can draw no lessons from history.

Dr. Blaisdell: Yes, you can draw lessons from history, but you can't make a law that is retroactive.

Chairman Bunker: Is there any further discussion?

Dr. Ellingwood: Just for Dr. Blaisdell's information, I would like to say this. Two boys were room-mates at school and one went to Yale and the other went to an osteopathic school. I know the boy who went to Yale quite well; he comes up to see me when he comes home. I asked him why his room-mate decided to take osteopathy. He said simply because he felt that he was getting the better training and application. I said: "Have you seen him?"

He said: "Yes, I have seen him."

I asked: "What is he doing?"

His answer was: "Just the same as I am."

So that they are both getting a medical education; using our books, I think sometimes alphabetically.

A Member: Mr. Chairman, I take serious objection to that. I would like to know the difference between poorly prepared and well-prepared, remembering that they are all poorly prepared. If you have not read the report of the Commissioner of Ontario, you should read it, and you will know that they are not receiving an education in medicine in any sense of the word.

Kirk's Bill, you will remember, offered clinical facilities of a 15-bed hospital, which at the time of inspection, had five patients. You can't call that clinical experience.

The best osteopathic school in the country is probably located in Philadelphia, where they have a hospital, on which staff there are several M. D's.

But there is no such thing as a well-prepared osteopath, and there is no osteopathic school in the United States which is offering adequate preparation in any branch of medicine, as we understand it.

Voices: Question.

Chairman Bunker: The question is, whether the House of Delegates will vote to rescind the vote made by them at the last meeting of the House of Delegates, or whether they shall maintain that vote and carry on.

I shall ask those who are in favor of rescinding that vote to raise their right hands.

[By the count of Secretary Carter, seventeen hands were raised.]

Those who are not in favor of rescinding the vote will please raise their hands.

[By the count of the Secretary, six hands were raised.]

Chairman Bunker: I believe the "Yeas" have it, and the vote stands to be rescinded.

At this time I wish to make an announcement. At a meeting of the Council, held on October 22nd, it was voted that the importance of the commercial exhibits be brought to the attention of the House of Delegates at the 1938 Annual Meeting, and all members attending are requested to visit these exhibits.

I might say that these exhibits are not confined to one room; they are in different rooms. I hope that you will all graciously attend them.

Another question to come up before the House of Delegates is the question of staff appointments. I have a letter here to Dr. Carter, written by Dr. Frederick Hill.

"Pursuant to the instructions of the House of Delegates, the Committee on Medical Education and Hospitals met with the Committee of the Maine Medical Association to consider the matter of staff appointments. At this meeting, the enclosed resolution was adopted, and this is to be presented to the Council and to the next meeting of the House of Delegates."

Now, the resolution is as follows:

"Resolution, passed by the Joint Committee of the Maine Medical Association and the Maine

Hospital Association, October 22nd, at a meeting in Portland, Maine.

"Staff appointments in hospitals should be determined by the Governing Board, in co-operation with the active professional staff. It is advised that this be accomplished by consultation with the Committee representing the active staff."

Now, to facilitate matters, I believe that it is my jurisdiction to hand this on to the Reference Committee, without further action, and you can take the matter up with the Reference Committee.

Dr. Webber: I feel, myself, that it should be taken out of the hands of the Reference Committee. If this Committee acts the way the other one did, I'd like to have something to say about that. I don't feel like leaving it in the hands of a Reference Committee.

Chairman Bunker: What is your pleasure?

Dr. Webber: I would like to say, in regard to that report, that for a long time, there have been advances against the profession, as you know, and as you heard a few moments ago from Dr. Wakefield, the osteopaths, at the next session, intend to try to become members of hospital staffs, and also, in the resolves of the A. M. A. one of the first ones was this:

"All features of medical service in any method of medical practice should be under the control of the medical profession. No other body or individual is legally or educationally equipped to exercise such control."

I feel very strongly in regard to this report, which came out in our Journal. I feel very strongly that it is extremely inadequately worded. The word "co-operation" is too elastic, and I would like to have the House of Delegates here take up the following resolution.

I move that staff appointments in a hospital shall be made by the Governing Board, but only from recommendations made by the Visiting Staff. Such appointments shall be made as are mutually acceptable to a majority of the whole governing Board and a majority of the whole staff. Exceptions shall be made to government hospitals, private hospitals and hospitals maintained by a religious order.

I feel that we have got to stand on our own feet, and that it is necessary to make it emphatic that hospital staffs shall be nominated by themselves.

The governing boards of all of our hospitals are the laity and they are more and more inclined to feel that they should take upon themselves the whole control of the staff. You have seen it in Portland, in Lewiston, and you are going to see it in all of the other hospitals in the very near future.

I feel that this House of Delegates should take up this resolution and put it through. I move that it have a passage.

Chairman Bunker: Dr. Webber, we already have this resolution before the House, and we will listen to discussion further and then vote on the resolution.

Is there any further discussion on Dr. Hill's resolution?

Dr. F. T. Hill: You gave the impression that it is my resolution, and also in your letter that it was a joint committee with the Committee from the Maine Hospital Association. Actually, that was the best compromise that we were able to get.

Now, I suggested, because Dr. Leighton was not there, that the nominations to staff appointments germinate in the active staff. Mr. ——— representing the Maine Hospital Association, said he never would accept it.

Our feeling was that that was a safeguard, and that if all appointments were made in co-operation with the Committee from the staff, that was the best we could do.

Now, if we can push anything further down their throats and make it stick, it will be all right with me, but I doubt if it can be done. I am speaking merely in defense of the original resolution.

Chairman Bunker: Is there any further discussion on this resolution?

Dr. Webber: I don't have any question but that it can be done. We must stand on our own feet and put it through. They are going to put us under unless we do. The very fact that they would not co-operate is indicative of that.

Dr. Pratt: I am not sure which resolution I am speaking on. I think Dr. Webber is absolutely right. I think that staff appointments should originate from the active staff. Of course, they should be appointed by the boards.

I think that Dr. Webber's view is right, and we should back it up.

Dr. Thaxter: I should like to ask for some information. If we pass this resolution, where are we? We can pass a resolution that it is our opinion that appointments should be made in this manner, but after all, it is up to the Board of Trustees of the hospital.

If we merely say that it is our opinion that that should be done, it will give them an idea of what we are thinking, but I don't see how we can pass a resolution stating that they shall do such and so.

Dr. Webber: The difference between the resolution that I have offered and the decision of the hospital boards is very evident. From the very wording of the hospital board's resolution, which are familiar terms to us, it shows that a matter of co-operation to them means that they will do what they want to do, and you will do what they want you to do, also. They do not wish to confer with the whole staff; they want to take two or three men, whom they will pick out themselves, the ones that they are subsidizing, and get their opinions, maybe. In our hospital, they are paying nine or ten men wages, and those are the kind of men they pick out for their information.

I think very strongly that this isn't a question for the laity to decide; it is a question for the medical men to decide. We should stand on our own feet and decide whether one thing is right or otherwise, or the other thing is right.

You all must feel, deep in your hearts, that the medical profession is the only profession to pick out men to be on the staff, and that they should have the say of it.

On this resolution, the governing board has the right to refuse to appoint men; but they will only appoint men satisfactory to the members of the staff whom they control.

In my resolution, the staff can come back, when an appointment is refused, and they can come back again and again with the same appointment.

In our hospital, in the beginning, the men on the staff wished to appoint a man named Dr. ———, one of the best men in the town. But, some enemies of his were on the governing board, and they refused to appoint him. The staff came back again and again. Then the staff appointed Dr. ——— in his place. That is the only way to do; come back and come back again and take the recommendations of the staff.

I believe that if we can come out strongly in that way, that they know we feel that way and they will come down and do just what we want them to do.

Dr. Foster: May I ask Dr. Webber to read his resolution as he has it, again?

[Dr. Webber then read his previous resolution.]

Dr. Webber: You will find every one of the hospitals is governed by a board of directors; this is true all through the State. And, under their way of doing things, they are going to nominate their own staff; they are going outside, to Boston or somewhere and pick up a man and put him in, in spite of the fact, and regardless of whether the staff wants him or doesn't want him. They are going to keep him there.

Chairman Bunker: I don't believe there is any feeling against Dr. Webber's idea. I think the House of Delegates probably are in sympathy with him.

Dr. Hill has already expressed his feeling, and anything for the benefit of the society would be agreeable to him. My idea of placing it before the Reference Committee was that I thought it could be dealt with properly and referred back to the House of Delegates. Otherwise, we will have to proceed.

Dr. Oram: I move that the question be tabled for further consideration. It is a subject that should not be popped off in a pop-gun manner. It is something that the medical profession needs to do, to stand upon its own feet, and not be dictated to by somebody who has a familial relationship to some chiropractor or osteopath. The medical men are the only people who are competent to judge their companions.

Therefore, I move that this matter be tabled.

Dr. Hill: Mr. Chairman and Gentlemen. I should like to see all this sort of thing done, but I think we have got to have the co-operation of everybody.

What we are faced with at some future time is this. At sometime, there will be a campaign on the part of some folks for hospital positions, and we are not going to be able to stop that, as a medical profession. We have got to have the support and co-operation of the Maine Hospital Association to do that. They have more political control than we have or will have. We have got that so far.

Now, if we could get the substance of Dr. Webber's motion before these people, it would be lovely. But, I would like to see it obtained by co-operation and not coming out and saying: "Here, we demand this." Because, if we do that, we may lose that support on this other question, and that is pretty important.

Now, in the discussion of this question, the original question of staff appointments, it was brought out at this meeting that the hospital directors feels that they represent three interests and we represent one. We represent the professional end of it; they represent the invested funds of the hospital, the patient public and they seem to have an idea that perhaps the patient public needs protection from the medical profession; I don't know. Therefore, their thought is that they never would accept a resolution which said that every appointment *must* germinate from the medical staff.

Now, if we can get that by co-operation, that is fine. I believe what we want now is the feeling of the House of Delegates for the State Association.

My suggestion is that this resolution be thrown aside, and that this new resolution, if it is what you want, be referred to a new Committee, said Committee to meet with the Committee from the Maine Hospital Association for this matter. Don't try to fight them, but co-operate with them.

Dr. Webber: I don't agree with that at all. If you don't fight and if you don't stand on your own, you won't get anywhere. If you willy-nilly with them and let them have everything as they want it, they will say:

"The other men in the Maine Association won't stand behind it; you haven't any backing."

And then they will do just as they want to do. The only way you can clamp down on that type of man is to tell them what they have to do. If the Maine Medical Association tells them what they have got to do, then you will get it. On our governing board of directors, I know for a fact that three or four of them have recommended osteopaths, and for the rest of the staff, when there are openings, they go to Boston when they need anything.

Do you think you will have anything different? Well, you won't. You will have the same thing in every town. Lewiston isn't the only town where this will exist.

I say again that we ought to stand on our own feet and fight.

Chairman Bunker: There is a motion before the House to table the question. Before I ask for a second on this motion, I would like to know if there are any other comments.

A Member: I move that this matter be referred to the Reference Committee.

A Member: I believe Dr. Webber's motion has preference.

Dr. Oram: I don't know that I am sure about this, but I rise to a point of order. A motion to table a matter has precedence over any motion that hasn't been voted upon.

Dr. Bliss: Does that mean that you can throw it aside? When are we going to consider it?

Dr. Oram: I withdraw the motion.

Dr. Bliss: He has appointed his Reference Committee, now, and this is referred to the Resolutions Committee, where any of us can go and tell them what we have to say. Then it is referred back to the Committee.

Dr. Webber: If you put it in the hands of a Committee, you will kill it.

Dr. Bliss: The Reference Committee re-vamps and re-words the thing and brings it back here to the House of Delegates tomorrow.

Dr. Williams: There are quite a few motions floating around here. So I would like to make another one.

I move that the recommendations of Dr. Hill's and Dr. Webber's resolutions be referred to the Reference Committee, in order to get this thing into shape, and that a report be made to the House of Delegates' meeting tomorrow afternoon at five-thirty.

This motion was duly seconded by several of the members present, and was carried.

Dr. Foster: Under the heading of New Business, the Chairman of the Council would like to present this for your consideration:

The Council, appreciating the value to the members of the Association of the Autumn Clinical Sessions, recommend that the House of Delegates amend the by-laws to authorize the officers of the society to make the Annual Fall Session a regular annual clinical meeting, and to authorize the Scientific Committee to have general oversight of the meeting, in co-operation with the local County Society conducting the meeting, and also authorize the Treasurer of the State Society to pay the bills contracted for the program and speakers.

Chairman Bunker: Gentlemen, you have heard the motion made by Dr. Foster.

Dr. Foster: That is a recommendation from the Council, you know.

Dr. Knowlton: I move that the recommendation of the Council be accepted.

This motion was duly seconded by several of the members present, and was carried.

Dr. Plummer: Is it in order, now, to make a motion about the annual dues?

Chairman Bunker: The annual dues have been set by the Society. I didn't know it was customary to vote on them. I think the motion is out of order, because I don't believe that we vote on that each year. The dues have been established by the Society.

Dr. Hill: May I have the privilege of the floor for a moment? There is one matter that I would like to bring before the attention of the Association. You can see why I am holding it over until the present time.

I have felt for sometime that our set-up regarding the Council was somewhat weak. We have considered this thing with reference to other national societies, in that the outgoing officers who have been conducting the policies of the Association were not continued.

I would like to suggest to the House of Delegates the advisability of so changing the make-up of the Council as to include as an extra member the immediate past President.

Chairman Bunker: Do you make that in the form of a recommendation or a motion?

Dr. Hill: I can't make a motion; therefore, I recommend it.

Chairman Bunker: You have heard the recommendation, Gentlemen, that the immediate past President be retained as a member of the Council.

Dr. Hill: If it is acceptable to the members, I think it could be referred to the Reference Committee. The whole thought, of course, is to carry on. The out-going man would be very valuable to the Council next year.

Chairman Bunker: If there are no objections, we will refer that matter to the Reference Committee.

Is there any further new business to come before this meeting of the House of Delegates?

Dr. Webber: I would like to ask who is on that Committee, to look over that new bill.

Chairman Bunker: Dr. Thompson, Dr. Blaisdell and Dr. Haskell of Lewiston.

Dr. Webber: He isn't here and won't be here.

Chairman Bunker: In the absence of Dr. Haskell, I believe I have authority to appoint another member of that Committee. I appoint Dr. Will Bolster from Lewiston as the third member of that Committee.

Dr. Ellingwood: I recommend that we have a Committee of at least five. That is just a recommendation.

Chairman Bunker: I shall be pleased to appoint Dr. Ellingwood on that Committee, and also Dr. Carl Stevens.

Is there anything further to come before the meeting?

Dr. Cobb: There is to be entertainment for the doctors and ladies this evening. There will be some fine moving pictures on the circulation of the blood, which will be well worth while seeing. If you get tired of the moving pictures, then I might say that some of the boys have promised to put on a half hour of magic things. [Applause.]

Chairman Bunker: If there is no further business to come before the meeting, a motion is in order to adjourn.

A Member: I move that we adjourn.

This motion was duly seconded by several of the members present, and was carried.

[Whereupon, the Sunday Afternoon Meeting of the House of Delegates was adjourned at seven o'clock in the evening.]

❧

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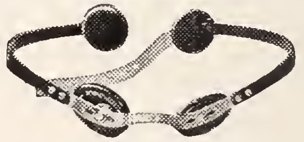

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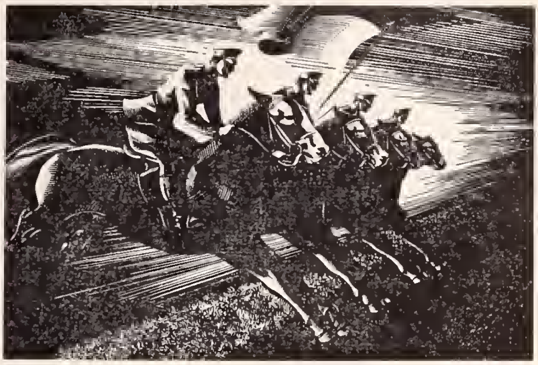

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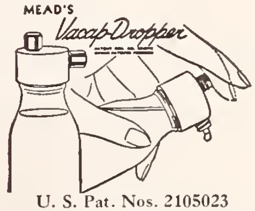

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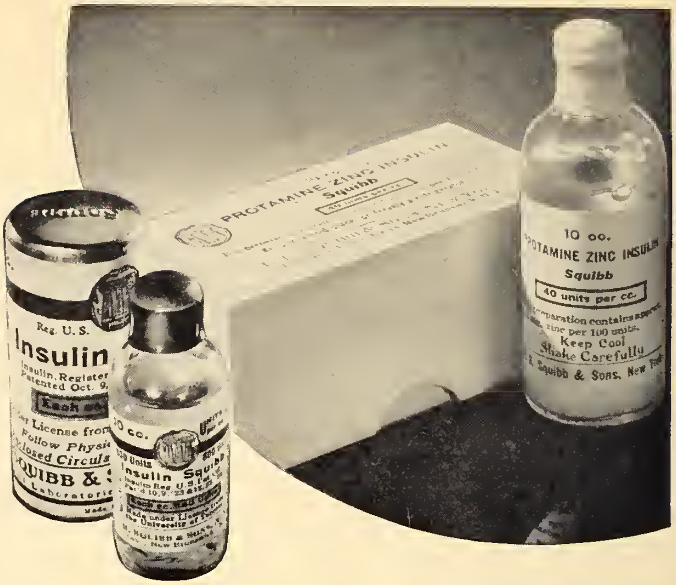

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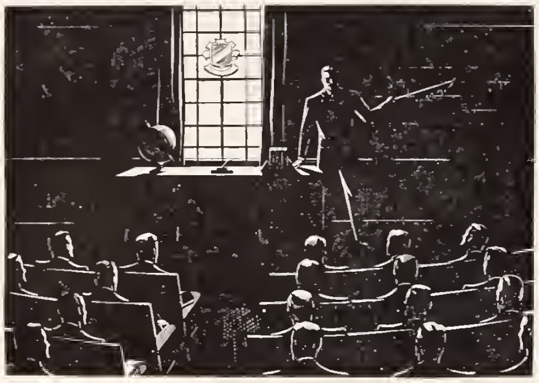

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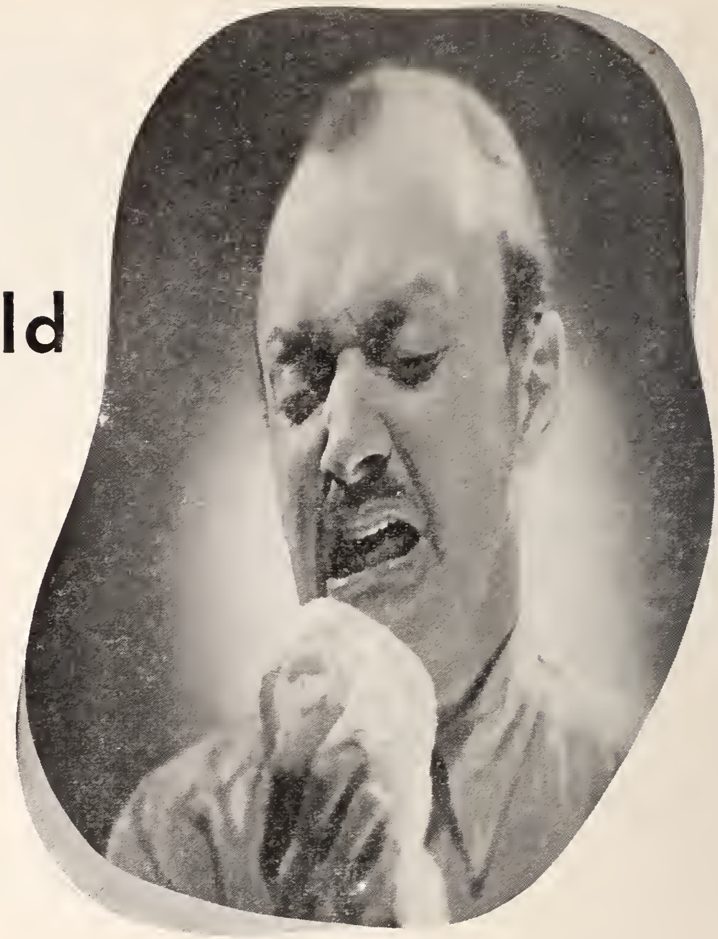

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*Metropathia Hemorrhagica**

By Fuller Albright, M. D., Boston, Massachusetts

Members of the Maine Medical Society and guests! I was given as a subject, "The Relation of Endocrinology to Obstetrics and Gynecology." That was an impossible order. It seemed wiser to choose as a topic a gynecological disease entity which is not too rare, which is definitely a hormonal disorder, and the pathological physiology of which is at least partly understood. I selected metropathia hemorrhagica, a term first applied to a specific type of functional uterine bleeding by Schroeder in Germany in 1915.

I will start by stating that, from the point of view of its pathological physiology, I consider this condition a "continuous hormonal" amenorrhoea; from the point of view of hormones, a continuous estrinism with a hypo-progestinism. I will spend the majority of the remainder of my time in elucidating these expressions.

Since the disease is an amenorrhoea, it will be convenient first to say a word about the cause of menstruation so as to be in a better position to explain failure to menstruate. In my opinion one can be quite didactic now about the cause of menstruation. The endometrium is under the influence of only two hormones,-estrin and progestin, both from the ovary—and most everything the endometrium does depends on the different patterns in which these two hormones are presented to it. Thus under the influence of estrin alone during the first approximately 14 days of the menstrual cycle, the endometrium regenerates; the glands grow deeper; the columnar epithelial cells of the glands show mitotic figures. During the second approximately 14 days, if the patient has ovulated, there is the added influence of progestin from the *corpus luteum*. This manifests itself by causing a cessation of all proliferation and hence of mitoses and by bringing about secretory activity in the endometrial epethelium.

But what causes menstruation? It will be necessary first to define the term "menstruation." Some authors employ the term to refer to the casting off of the endometrium regardless of whether it is in the proliferative stage or secretory stage; others confine the term to refer to the casting off of a secretory endometrium. I prefer the former definition and will use it hereafter. However, it should be noted that bleeding from the endometrium without casting off of tissue is not menstruation, i. e., the term is not synonymous with uterine bleeding.

We are now in a position to examine what patterns of presentation of estrin and/or progestin to the endometrium lead to menstruation. This can be and has been worked out on gonadectomized monkeys and confirmed later on women. It turns out that there are two patterns which will cause menstruation. Pattern A: If one starts with an oöphorectomized monkey, the endometrium is, of course, atrophied and quiescent. If one then administers estrin, proliferation occurs; if one then stops the administration of estrin, the proliferated endometrium is cast off. Thus, the first cause for menstruation is cessation of estrin where only estrin has been acting. Pattern B: If one again starts with an oöphorectomized monkey and gives estrin, proliferation occurs; if one then starts giving progestin, while estrin is continued, a secretory endometrium ensues; now if one discontinues the progestin alone, menstruation again follows after a short latent period. Thus, the second cause for menstruation is cessation of progestin where both estrin and progestin have been acting. Since it is normal for women to develop a secretory endometrium during each menstrual cycle, menstruation in women is usually the result of the second pattern.

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* Read before the Maine Medical Association, Bar Harbor, Maine, June 28, 1938. From the Ovarian Dysfunction Clinic of the Massachusetts General Hospital, Boston, Massachusetts.

If such are the facts concerning menstruation, and I think they are, it will be seen that in the final analysis menstruation is due to the cessation of action of a hormone—be it estrin or progestin. It is obvious, therefore, that failure to menstruate can be due to two possible causes: A) a-hormonal amenorrhœa where no hormones are produced so cessation of production is impossible, and B) "continuous-hormonal" amenorrhœa where hormones are produced, but where periodic cessation of production does not occur. Pregnancy is an example of a "continuous-hormonal" amenorrhœa; I propose to present metropathia hemorrhagica as another such example.

What are the facts about metropathia hemorrhagica? What sort of a person gets the disease? What are the symptoms? What are the pathological findings? The disease attacks three types of individuals,—the young girl shortly after the menarche, the middle-aged woman approaching the menopause, and the woman with general debility at any age. The classical symptomatology is a period of amenorrhœa of several months followed by a phase of weeks or months or even years of continuous flowing or spotting. The amenorrhœa phase may be absent; recurring amenorrhœic phases may alternate with episodes of flowing. If the patient has molimina with her regular menstrual periods, such molimina are absent with this flowing; if she has dysmenorrhœa, that too is absent. The ovaries of such an individual contain no corpora lutea and usually one or more follicle cysts filled with fluid of a high estrin titre. The endometrium is much thicker than normal; the glands are deep, with dilated ends giving a "Swiss cheese" microscopic appearance to the cut surface; there are usually several bleeding points.

Such is the nature of the disease under discussion. It may be argued that a patient with the same story may turn out to be bleeding from an atrophied rather than a thickened endometrium. So she may, but that is another disease, I believe.

The first point I desire to make is that these patients, whether bleeding or not, are really amenorrhœic. The endomentrium is not being cast off; such bleeding as they have is merely surface oozing from a thickened endometrium due to degenerative changes.

In interpreting the disease from the pathological findings, one is apt to jump at two conclusions—one right and one wrong—in my opinion. Thus one would note the absence of *corpora lutea* and the absence of a secretory endometrium and conclude that, for one thing, the disease is associated with a hypoprogestinism. This, I believe, would be a correct conclusion. Then one would note the increased thickening of the endometrium, the result of increased proliferation of the cells, and connect this with the follicle cysts in the ovary and conclude that there was a hyperestrinism as well. This conclusion, I believe, would be faulty. When one measures the amount of estrin excreted in the urine in these cases, one finds decreased rather than increased amounts. After all, the endometrial changes could just as well be explained by a small amount of estrin acting over a prolonged time as by an increased amount of estrin acting for the normal time. It seems to me that the findings are best explained by assuming that the ovaries have lost their power of acting in a rhythmical manner, that the corpus luteum phase of the cycle has entirely fallen out, and that one is left with a continuous estrin production. To be sure, there are situations characterized by hyperestrinism and continuous estrinism (granulosa cell tumor of the ovary, excessive estrin therapy) which lead to metropathia hemorrhagica, but, in my opinion, it is the fact that estrin production is continuous rather than that it is increased which is the deciding point. I have now explained what I meant when I referred to the condition as a "continuous estrinism" coupled with a hypoprogestinism, producing a "continuous hormonal" amenorrhœa.

We are now in a position to consider the various therapeutic procedures which one might employ.

The greatest emphasis should probably be placed on non-specific therapy. By and large it is the run-down individual who develops this condition. Iron therapy should usually be employed, as anemia predisposes to the condition, and as the condition of course leads to an anemia. Attention to diet and general hygiene are most important. Underlying conditions such as foci of infection and tuberculosis should be looked for. Until more is known, probably shotgun prescriptions of vitamins are justified.

Next for consideration come up a series of measures which are not designed to cure the disease, but to prevent its one most serious symptom—uterine bleeding. These include hysterectomy combined with bilateral oöphorectomy, hysterectomy alone, and artificial menopause by x-ray or radium. In the majority of instances these procedures are to be deprecated. In a patient at the menopause, however, one of them may be justified. However, my chief reason for picking the subject which I have was to urge that young women be handled conservatively. An artificial menopause or even the loss of a uterus is a major calamity to a young woman. Furthermore, radical therapy is not necessary. The alternative may be a long-drawn-out, tedious affair, but in the end most of these patients clear up. Sufficient iron therapy will usually prevent any severe anemia; death from hemorrhage is almost unheard of.

The next procedure I wish to consider is curettage. Of course in most cases it is desirable to perform at least one curettage to confirm the diagnosis and to rule out uterine cancer. A curettage is sort of a surgically-induced menstruation. Since the disease is an amenorrhœa, this procedure can be thought of as very reasonable. Indeed, after the removal of the hyperplastic endometrium, it takes about two months for another hyperplastic endometrium to develop and for the symptoms to recur. But one cannot be having a surgical curettage done every six weeks.

This brings us to a procedure suggested by Dr. John S. L. Browne of Montreal, which I will call a "medical curettage." The uterine bleeding due to the hyperplasia would be prevented if one could produce periodic menstruation. To produce menstruation one has to have cessation of a hormone —that of estrin or that of progestin. In this particular problem there is no simple way of causing cessation of estrin production. However, one could periodically administer progestin and, on withdrawing the drug, menstruation would occur (cf. Pattern B for producing menstruation). This is what Browne has proposed. It is a simple method of producing periodic menstruation and preventing endometrial hyperplasia until such time as the underlying disturbance in the ovarian cycle is corrected. It should be noted that it is not the purpose (at least was not originally) to correct the underlying trouble with this procedure, but merely to take care of one of its complications. In carrying out this treatment at the Ovarian Dysfunction Clinic, we have given in the neighborhood of 5 mg. of progesterone in oil intramuscularly daily for six days every six weeks.*

* Dr. J. S. L. Browne in a personal communication to the author stated that his usual dosage is 5 mg. of progesterone every other day for four injections. He repeats the course 20 days from the first day of the previous menstruation, thus producing a period about every 28 days. He emphasizes that it is unnecessary to give as much progesterone as would be necessary to produce a secretory endometrium as he has had success with as little as 2 mg. every other day for four injections.

Finally, there come up for consideration those agents which aim at restoring the normal ovarian cycle. The anterior-pituitary-like hormone (A.P.L.) from the urine of pregnant women was first tried for this purpose. It was hoped that this would stimulate the production of a *corpus luteum* in the ovary. As a matter of fact, A.P.L. seems to be singularly ineffective in producing *corpora lutea* in primates; none the less, for some unexplained reason, its administration often causes cessation of bleeding in metropathia hemorrhagica and not too infrequently completely corrects the condition. In the Ovarian Dysfunction Clinic at the Massachusetts General Hospital, there have been multiple instances where secretory endometria were obtained following its use and not unlikely because of its use. The follicle-stimulating hormone (F.S.H.) either alone or with A.P.L., can be tried in an effort to produce a *corpus luteum*. At the present time in our Clinic, we are very much interested in progesterone. We not only find that it does all the things which Browne said, but we have considerable evidence that it in some way helps in restoring the normal ovarian cycle. However, since one of the chief points I wish to make is that most of the patients get well in time anyway if the surgeons can be kept from doing a radical procedure, one cannot be too sure on this point.

Discussion

By Henry Knowlton, M. D., Bangor, Maine

Dr. Henry Knowlton: We are very much indebted to Dr. Albright for his efforts in our behalf. It is a long and rather tedious trip to Bar Harbor from Boston, and we are indebted for his coming here and talking to us about a subject, about which most of us know nothing. I have had the advantage, in that I have had his paper to read and re-read during this past week, but I still don't know anything about it. It seems rather sad that the practice of medicine does not become more simple. I still believe that some leader should write a small book about the things we should know, but someone always develops a new incident and new hormones are isolated and literally thrust upon us.

There are only two things that I can say about this paper, and both of those things are questions.

In the question of diagnosis, did you do a routine D and C for that purpose or do you make your diagnosis largely upon the history and the parents and perhaps the physical examination?

In the second place, is there any danger in the using of large amounts of these various hormones?

Since they are things about which we don't know very much, and since they are new and since they are readily available, we are encouraged by all the detail men who call upon us to use them in larger and larger amounts, either the ovarian or such of the anterior pituitary things that we have. Is there any danger in the use of these?

President Wakefield: I am sure that some one else will have some questions or discussion on this subject.

Question: I should like to ask what the commercial name for progestin is.

President Wakefield: Are there any other questions or discussion? If not, I shall ask Dr. Albright to close the discussion on his paper.

Dr. Albright: About this economic situation, I, personally, feel that most of these people whom I have seen, young women who have had their ovaries removed, I feel that the economic life is pretty bad from that time on. I think there is danger in this economic situation, because so many of them get so thoroughly upset; I think the economic situation is very often worse than before.

Perhaps I didn't emphasize the fact that I do think that although they may bleed and have this continuous bleeding, I do not think that they often end fatally. They can bleed outwardly, despite this. Give them iron, and they will go along. They may be annoyed at it, and they may not like it, but they will go along on it, year in and year out, and eventually they will get better.

We don't do anything routinely. I think a D and C is very often necessary, to be sure you haven't cancer. I think if you do an endometrial biopsy, you can be pretty sure of the condition, and you don't need to do a D and C. Try her out on some therapy for a while, and I don't think you will have to do a D and C. But, in most cases, you may want to do a D and C, to start with.

You do get a terrific hemorrhage in the first menstruation, and I think it is Dr. Browne's feeling that it is better to clear the decks first by the D and C and get everything out; then start the artificial menstruation, so to speak, about five weeks later.

As to the danger of hormones, I do not think that any of these hormones have any particular danger connected with them, and certainly there is not as much danger as there is in taking out the ovaries. We used to think when we gave A. P. L. therapy, we might run the danger of wearing out the ovaries and pretty soon there would be no follicles left to ripen, and you would get an early menopause. But with this therapy, you only get the follicles that have already started ripening. You do not start the little ones. They have to reach a certain maturity before they respond to the therapy. With F. S. H., on the other hand, you can start the follicles going, and there might be danger in doing that, too continuously.

The commercial name for progestin is progesteron, and is marked under the same name. It has been synthesized and marked by the Scherick Corporation.

Question: I would like to ask whether or not the thyroid is involved in the mechanism of this disease and about the use of thyroid.

Dr. Albright: I don't believe that thyroid is specifically involved. In hyperthyroidism, or in a run down condition, you may get perhaps not the disease but in some way a symptom of it. I do believe that thyroid therapy in almost any one of the diseases in this general condition does, occasionally, do good and does benefit the patient, even when you can't demonstrate hyperthyroidism. I think in many of these cases, you can try thyroid therapy and get the benefit therefrom, but as to any specific connection, I do not know. (Applause)

Painful Conditions of the Heel

By Elmer M. Tower, M. D., Waterville, Maine

Pain in the heel frequently occurs in persons who stand or walk a great deal, but may also arise from other causes. Whatever the cause, the pain is usually aggravated by use, and may be absent during rest. The painful area can always be found by palpation.

Painful conditions about the heel most commonly met with may generally be traced to one of the following three causes: (1) Traumatic Disturbances, (2) Pathological Disturbances, (3) Static Disturbances.

1. The effect of Trauma. Pain resulting from Trauma may be situated in the back of the heel around the insertion of the tendo-achillis or on the plantar aspect. When situated in the region of the tendo-achillis, the underlying conditions are: Tendo-synovitis of the tendon sheath, the formation and irritation of the enlarged bursa, and partial tears of the tendon. In all cases the pain is rendered worse by movement and may be completely relieved by rest.

A. In Tenosynovitis there may be swelling due to effusion about the tendon, accompanied often by a silky crepitus, and when the condition is chronic, there may be an actual deposit of fibrous tissue in and around the tendon giving it an irregular form on palpation. When these fibrous deposits project backwards, the wearing of a boot or shoe is very uncomfortable.

B. Bursal enlargements may affect the following bursæ:

Bursa postcalcanea superficialis is found between the tendo calcaneus (Achillis) and the deep fascia.

Bursa postcalcanea profunda (B. tendinis calcanei) is placed between the tendo calcaneus and the posterior surface of the os calcis.

Bursa subcalcanea lies between the inferior surface of the calcaneum and the plantar fascia.

The symptoms of bursitis about the heel are: swelling, pain on motion, and tenderness localized over the bursa. Fluctuation may be present, and the skin overlying the swelling is often red and œdematous.

C. Periostitis is generally at the site of insertion of the tendon-achillis, which may be due to strain at the insertion. In growing children this may be mistaken for apophysitis. The diagnosis is made by localizing the tenderness a little lower down than in the case of bursitis and by the absence of deep fluctuation in the bursa beneath the tendon. The treatment of the above conditions is essentially rest from weight-bearing. In tenosynovitis, if it is necessary for the patient to continue walking, a raise of the shoe of one-half inch to three-quarters inch on the heel will relieve some of the pressure. This condition may become chronic if the patient continues walking, and in the chronic condition one may add massage, contrast baths and sharp counter-irritation by liniment or cautery. If the pressure of the back of the shoe is painful, it should be split.

In the treatment of bursitis, the tension should be relieved by raising the heel three-quarters of an inch and by a strap applied around the leg above the malleoli to act like a wristlet worn by workmen who have a sprained tendon in the wrist. Stiff leather counters should be removed if irritating to the heel, and the patient instructed to walk only a little each day. This condition may become chronic and develop a fibrosis of the walls of the bursa so that removal of the bursa is required.

The treatment of periostitis. Rest is the essential thing. This condition may become chronic, and it may be necessary to relieve tension by an osteotomy one-fourth inch into the bone. This should never be done during childhood on account of the growing epiphysis.

Fractures of the os calcis and a traumatic sub-taloid arthritis are two conditions which also give a painful heel, but this paper is limited and the details of these conditions will not be discussed.

2. Pathological Disturbances. Apart from Trauma, pain in the heel may have its origin in organic diseases of the bone or epiphysis, and the infection may be tuberculous, syphilitic or pyogenic or may follow a general gonococcal or rheumatic toxemia.

A. Osteochrondritis or Apophysitis is a term used to signify a non-inflammatory derangement of the normal process of bone growth which may occur in the epiphysis of the os calcis as well as other epiphyses in other parts of the body. It is well remembered that the os calcis is the only bone of the tarsus invariably having an epiphysis.

Symptoms of Apophysitis occur between the ages of nine and thirteen. Clinically the disease occasions little more than a slight aching pain and a limp after exertion. Upon examination, there is tenderness, swelling, redness over the posterior part of the heel, and the diagnosis is confirmed by an X-ray picture which shows fragmentation of the epiphysis. The treatment is immobilisation and rest from weight-bearing from six to eight weeks.

B. Tuberculosis of the Calcaneus. This is usually situated in the anterior part more than in the posterior region of the bone. An X-ray materially aids in the diagnosis of the condition and shows a degree of bone atrophy which is not found in epiphysitis.

C. Pyogenic Infection. This produces marked inflammatory reaction and destruction of bone. In this condition there may be a bone abscess of the os calcis, which is very painful on weight-bearing. Treatment is by operation and cleaning out the infected bone.

Spurs of the os calcis. These are rare in early adolescence and are found on the inferomedial aspect of the calcaneus. Spurs develop on the under surface of the os calcis at the point of attachment of the plantar fascia. Here the site of maximum tenderness is farther forward than in the previous conditions, and the X-ray shows an irregular ossification extending forward from the anterior surface of the tuberosities of the os calcis. Gonorrhea and other inflammatory conditions have been named as a cause of the outgrowth, but there is no evidence that they bear any relationship to it. The spurs run forward into the plantar fascia or short muscles of the sole and are frequently seen in X-ray pictures of the os calcis. They often cause no symptoms, but on the other hand, if the patient accidentally jumps onto a stone and bruises the periosteum over one of these spurs, it may become enlarged and an adventitious bursa may develop over it and in this condition the patient feels pain every time he puts his heel to the ground. Sometimes such outgrowths are accidentally discovered when the foot is radiographically examined for some other purpose. It is evident, therefore, that care is necessary before attributing the patient's symptoms to the spur when one is demonstrated. As far as treatment goes, the use of sponge rubber or soft felt heel pads is usually all that is necessary. In arthritic patients the usual general treatment must be instituted in addition. In some cases surgical removal of the spurs is needed, and this is done through a lateral incision. Oftentimes they recur after removal.

3. Static Disturbances. Pain in the heel is a comparatively common and often troublesome complaint met with in the feet under a variety of conditions. Actually, tenderness, especially upon walking, rather than spontaneous pain, is the main symptom, but occasionally the latter is present with or without tenderness.

This condition is due to many causes, so that each case has to be investigated carefully before any conclusion can be reached. Even so, in some cases, no adequate physical lesion can be discovered to account for the pain, and a diagnosis of neuralgia or neurosis is the only one possible. In a commonly seen type the tenderness is associated with some change in the habit of the patient, who has taken up a fresh occupation involving much more standing or walking than his feet have been accustomed to. In such cases we may assume that the fibro-fatty pad of the heel, together with the overlying callous skin, has not had time to respond, as it should do, by increase in thickness and density, sufficiently to withstand the excessive hammering to which it is subjected. The "buffering" function of these structures is thus inefficient, and the shocks are transferred to the sensitive periosteum of the os calcis, setting up a mild traumatic periostitis. A more gradual introduction to such a change will usually avoid the difficulty, but once the condition is established, the deeper structures appear to become unduly sensitive, so that it is frequently necessary to abandon the particular occupation before relief can be obtained.

Treatment. Pain localized in the heel is easy to treat if there is some obvious cause, but where this is not so the outlook is not so happy. X-ray examination may reveal more or less well-marked spurring under the calcaneus, definite foot deformity, talipes calcaneus or cavus, pain in the heel being due to the more vertical position of the calcaneus. Treatment consists in correction of the deformity. There are other cases, again, chiefly in young patients, where no morbid condition can be found, and though certain of these are probably neurotic in origin, others may be due to foot strain or fibrositis, X-ray evidence being negative. If rest, followed by the use of cork soles, cupped over the tender area, does not cure the condition, the origin of the planta fascia and short muscles may be separated from the under surface of the calcaneus, as in the Steindler operation for a claw foot. This may be done by reflecting a heel flap forwards, but it is usually more satisfactory to perform the separation through medial and lateral incisions, leaving the heel flap attached behind.

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Meeting of the New England Otological and Laryngological Society, Massachusetts Eye and Ear Infirmary, Boston, Mass., February 16, 1938

Abstract Editor, Dr. Werner Mueller; Presiding, Dr. Frederick T. Hill

SEROUS LABYRINTHITIS. DR. HARRY BUTLER, BANGOR, MAINE.

The author studied 16 cases of serous labyrinthitis over a period of nine and one-half years. The ages ranged between 45 to 60 years. None of the patients fulfilled the postulates of Meniere's Disease.

Since the author regards this type of labyrinthitis as an endorgan hyperemia and serous inflammation, he devised a method of treatment by means of which the endorgans in question were put to rest. For a period of three weeks the patients were put to bed flat on their backs, with only a baby pillow. They were not allowed to move their heads. At the same time dehydration was carried on by a preliminary catharsis, pilocarpine by mouth and a limitation of the fluid intake. Since nearly all cases had some Eustachian Tube inflammation with decreased patency, periodic E. T. inflations and shrinking of the nasal mucosa were carried out. After the treatment had been terminated, the patients were allowed to increase their activities gradually, until in six weeks they had resumed normal functioning.

DISCUSSION by Dr. M. H. Lurie: Dr. Lurie regards the treatment by immobilization as entirely rational. He has, however, given up the administration of pilocarpine as being of no particular help.

THE SURGICAL TREATMENT OF CHRONIC DACRYOCYSTITIS. DR. SAMUEL W. GARFIN.

After outlining the history of the treatment of chronic dacryocystitis, the indications for the West operation were cited. The author used the transseptal route. The right tear sac is approached through an incision of the septum from the left vestibule and vice versa. The incisions on both sides of the septum are made in such a way that they do not lie in the same plane in order to avoid a permanent perforation. In this manner the operative field is brought into better view and the technical difficulties encountered by the approach through the same side are greatly eased.

Twenty-eight operations were performed by this method over a period of twelve years. The greater number of these patients could not be followed up to date and were therefore not offered as statistical criteria. However, Kofler was cited as having had approximately 90% cures in many hundreds of these operations over a period of some twenty years.

Discussion: Dr. C. T. Porter doubts that the author's method offers any advantages over the Mosher-Toti operation except the lack of a possible external scar. On the other hand, the intranasal route offers a great many more difficulties, especially in cases that have to be reoperated.

Dr. Garfin admits the difficulty of an eventual reoperation. He claims, however, that the external operation necessitates a disarrangement of the structures in the region of the external canthus, with a possibly resulting impediment of tear flow into the nose. Furthermore, the transseptal operation facilitates the approach to the anterior ethmoidal cells, suppuration of which is regarded by some as an etiological factor in chronic dacryocystitis.

UNDIFFERENTIATED NEOPLASM OF THE THYROID AND LARYNX WITH MULTIPLE METASTASES. DR. A. L. MACMILLAN, CONCORD, N. H.

Case Report: A 63-year-old male whose chief complaint was pain in the left side of the neck and increasing hoarseness. When first seen, several weeks after the onset, there was a slight enlargement of the left lobe of the thyroid. Biopsy taken from the thyroid was diagnosed as chronic thyroiditis and adenoma of the thyroid. The larynx showed no remarkable changes at this time. Two months later a small mass was seen on the anterior wall of the trachea. Biopsy from this was diagnosed as epidermoid carcinoma grade III. A month later the patient died of a broncho-pneumonia. Autopsy showed the primary growth to be in the thyroid, with secondary invasion of the larynx. There were also metastases in the pericardium, the heart, the pleura, the lungs, kidneys, adrenals and pancreas.

PRELIMINARY STUDIES OF THE BLIND SPOT IN HEAD INJURIES. DR. HOWARD F. HILL, WATERVILLE, MAINE. BY INVITATION.

The value of complete visual field studies in cases of head trauma has long been known, whereas but little attention has been paid to the blind spot and its changes in such injuries.

In all cases of major and minor head injuries, a careful daily check should be kept of changes in the contour and size of the blind spot. A persistent increase in its size indicates severe trauma and probably some increased intracranial pressure or edema. Its changing contour often gives an accurate index of the rise and fall of intracranial pressure, from day to day. In this respect it is a far more sensitive indicator than either the peripheral field or the nerve head.

The author examined the blind spots of college boys after boxing bouts with lightweight gloves. Two or three minutes after having received blows on the head severe enough to cause temporary vertigo, the blind spots of the boxers were charted and the fundi examined. In all such cases enlarged blind spots were found. They persisted for from three to fifteen minutes and then gradually returned to normal. At the same time the fundi remained normal throughout.

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The President's Page

To the Members of the Maine Medical Association:

Having traveled several hundred miles during the last month and having visited several County Societies, on which occasions I have been fortunate in becoming personally acquainted with as many members as possible during my short visits, I have been greatly impressed with the enthusiasm and keen interest prevailing among the older members of our State Society, in regard to the National Health Program which appears to be the topic of discussion at the present day.

These men in the northern and western part of our State, remote from the larger surgical centers, handicapped in the past by severe winters, bad roads blocked with snow—before the days of automobiles—still proclaim that they have been faithful to the public in fulfilling their duties regarding the care of the sick and needy in the communities where they were expected to render service.

These practitioners are all of the same accord in their views that the younger men now entering practice must necessarily carry on in the same manner as has been their custom in the past.

However, they are concerned with the fact that the recent graduates are prone to avoid the rural districts and to seek their livelihood in the larger centers where hospitals are available and all of the modern luxuries are at hand.

Because of this phase of modern medicine, these older men, to whom I have referred, are somewhat alarmed over the final outcome in regard to the proper treatment of the people, who must necessarily, because of their occupation, reside in remote rural districts.

Personallv, I have the highest regard for the opinion of these Pioneers of Medicine who have served the public so faithfully and have gone about their work so graciously, performing deeds of charity and self-sacrifice, and I cannot help but wonder if the graduates of today are preparing themselves for such arduous tasks as have been undertaken by their forefathers, with the same consideration for the poor and needy and the value for services rendered placed on the same standards in accordance with the trend of times.

To me this is an important issue and is one of the questions that must be decided before we have settled the problem of Socialized Medicine.

Willard H. Bunker, M. D.

Editorial

The Importance of the County Secretary

At no time in the history of organized medicine has there been so many perplexing and important problems. Never so great a need for individual and collective effort. These problems, while nation-wide in scope, vary greatly in different localities, and under the set-up that obtains in our National and State organizations, many important duties fall on the shoulders of county officers. As a rule, county secretaries are not involved in the annual change of official assignments, it being recognized that a long continuity of office obtain in that of the secretary, who rightly is considered a most important member of medicine's official family. Much depends on his appreciation of what his office really means, for if conducted in an attitude of *laissez-faire,* both his County and State organizations are deprived of much needed assistance.

As has been stated before, probably at the risk of becoming tiresome, the importance of the most careful selection of the physician to carry on in this important capacity should be the concern of every member in each county society. It is through and by him that the society is kept on its toes; true beyond argument that many times it is a bothersome task to attend to what may seem trivial requests and details, but it is disconcerting, to say the least, to have questions and requests entirely ignored.

What goes on in a given county society is not only of importance to it but to the State association as a whole. The Journal of the State Association relies on the Secretary to obtain and forward the papers read before it; interesting case reports are often presented which are of great clinical interest to all, and his is the duty to promptly notify the Secretary of the State Association of the passing of a colleague so that the JOURNAL may make prompt recognition, and it is extremely important that such notices be received promptly.

Some of our county societies can well point with pride to secretaries past and present. They recognized their responsibility and welcomed the opportunity to be of service. Regrettable as it is, however, some secretaries seem to view their position as of little importance, with the result that the society merely drags along and far from obtains the objective so necessary in these days and times. The complexity of many matters to-day, scientific and social, demands a great deal of study in order that the best results may obtain, and the secretary who does not assume his share of the burden surely does not appreciate his obvious duty. The officers of the State Association rely to no small degree on the combined and individual efforts of these men, so it is again asked that every secretary in Maine recognize the prestige of his position and bring to it a spirit of loyal coöperation and much needed help.

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County News and Notes

Aroostook

The October meeting of the Aroostook County Medical Society was held at Fort Fairfield on Tuesday evening, October 11th, with thirty-four members in attendance.

During the chicken pie supper Mr. and Mrs. William Jenkins rendered several vocal selections and Dr. Wilfred Brewer entertained on the piano.

At 7.30 P. M. the business meeting was opened by President Norell.

Delegates to the Maine Medical Association 1939 Annual Meeting were elected as follows: Delegates, Drs. W. B. Gibson and H. E. Small. Alternates, Drs. Storer Boone and Arthur Whitney.

The proposition as made to the Society for the indigent sick by the Farm Rehabilitation Board was tabled until further discussion by the Committee appointed to act upon it.

Three applicants to the Society were admitted to membership: Drs. Gerald Donahue, Onil Labbe and Wilfred Brewer, all of Presque Isle.

Dr. George Coombs of the State Department of Health was the first speaker on the program and talked of the Department's plans for pneumonia control and on the present use of C-vitamic acid in treatment of scurvy.

Dr. Willard H. Bunker, President of the Maine Medical Association, then gave an interesting review of the State activities and outlined plans for the future to benefit the Association.

The guest speaker of the evening was Dr. William Ellingwood of Rockland, Maine Medical Association delegate to the House of Delegates of the American Medical Association. A most instructive hour was enjoyed when Dr. Ellingwood reviewed the high points of the recent meeting of the House of Delegates, events leading up to the Federal overtures and organization and methods necessary to arrive at a beneficial program for both the profession and the laity. Considerable informal discussion followed Dr. Ellingwood's paper.

The meeting was adjourned at 11.15 P. M.

Respectfully submitted,

ARTHUR T. WHITNEY, *Secretary.*

Cumberland

The fall meeting of the Cumberland County Medical Society was held on Thursday, October 13th. A Clinic at the Maine General Hospital at 4.30 P. M. was very well attended. Dinner in the State of Maine Room of the Falmouth Hotel was followed by a short business meeting during which Kenneth Dore, M. D., of Fryeburg, Maine, was elected to membership, and Jack Spencer, of Portland, was admitted to membership by transfer from the Suffolk County Medical Society of Massachusetts.

The application for membership from Carl C. Corson was received and referred to the Council.

Dr. Swift, President of the County Society, spoke in reference to the return of the American Medical Association questionnaires on the Study of Need and Supply of Medical Care.

Dr. Swift also announced the deaths of four of the Society members. *Drs. Edville G. Abbott, Lester L. Powell,* and *Willis B. Moulton,* of Portland, and *Dr. C. W. P. Foss* of Brunswick. Dr. Moulton was an Honorary Member of the Society having received his Medal in 1933.

The following Nominating Committee for 1939 Officers was appointed: Edwin W. Gehring, Chairman, Roland B. Moore, Langdon T. Thaxter, and Thomas A. Foster.

Dr. Bunker, President of the State Association, was present and talked on matters of interest to the State Association.

Dr. Moore showed Obstetrical moving pictures.

HAROLD V. BICKMORE, M. D., *Secretary.*

Franklin

On the evening of October 6, 1938, a meeting of the Franklin County Medical Society was held at the Exchange Hotel in Farmington.

A short business meeting was held at which time Harry Brinkman, M. D., of Wilton, was elected to membership.

Dinner was served to a gathering of forty, including four members from Somerset County, three from Androscoggin County and one from Cumberland, Knox and Washington.

Speakers of the evening included Dr. Wallace Webber of Lewiston, Dr. George Pratt of Farmington, Dr. William Ellingwood of Rockland, Dr. Edwin W. Gehring of Portland, and Dr. Willard H. Bunker of Calais, President of the Maine Medical Association.

JAMES REED, M. D., *Secretary.*

Kennebec

A meeting of the Kennebec County Medical Association was held at the Central Maine Sanatorium in Fairfield, October 20, 1938.

Clinical Session at 5 P. M., presided over by Samuel H. Kagan, M. D., President of the Association:

1. Thoracoplasty, George C. Howard, M. D.
2. Malignancy of Seven Years' Duration, George C. Howard, M. D.
3. Tuberculosis-Pneumothorax, George C. Howard, M. D.
4. Bronchography as an aid in Differential Diagnosis of the Chest, Walter H. Modarelli, M. D.
5. Bronchiectasis, Walter H. Modarelli, M. D.
6. Empyema Cavity, Walter H. Modarelli, M. D.
7. Presentation of Case of Bilateral Thoracoplasty, Charles D. Cromwell, M. D.

Dr. Cromwell summarized the work as presented by his staff, and stated that the basis of treatment in Tuberculosis consisted of absolute rest and good food. Additional modalities consisted of Pneumothorax, Phrenic Nerve crushing, Pneumolysis, and Thoracoplasty.

An excellent dinner was served at 7 o'clock which was followed by a business meeting. Minutes of the last meeting were read and approved.

Allan C. Hurd of Gardiner, Maine, was admitted to membership.

The speaker of the evening was Dr. Walter Bauer, Associate Professor, Harvard Medical School, Physician in charge Arthritis Clinic, Massachusetts General Hospital, Boston, who discussed Arthritis, classifying the different types according to their causes, as trauma, infection, metabolic, of unknown origin. Dr. Bauer then described the different types, typical and untypical, and discussed the treatment of these different types, giving the remedies of real value, and mentioning those previously used but now found to be valueless. An interesting speaker, an authority on this subject, he held the attention of those present up to the last moment.

There were 37 members and guests present.

Respectfully submitted,

Frederick R. Carter, M. D.,
Secretary.

Frederick T. Hill, M. D., of Waterville, Maine, spoke before the American Academy of Ophthalmology and Otolaryngology, at a meeting held in Washington, October 12, 1938.

Doctor Hill advocated "rational surgery" in which the physician adapted the type of operation to the patient, rather than trying to adapt the patient to a particular operation.

Walter W. Hendee, M. D., of North Vassalboro, has announced that he is opening an office, three days a week, in Union.

Oxford

The Annual Meeting of the Oxford County Medical Society was held at Bethel Inn, Bethel, Maine, October 18, 1938.

The following Officers were elected:

President, Dexter E. Elsemore, Dixfield.

Vice-President, William T. Rowe, Rumford.

Secretary-Treasurer, J. S. Sturtevant, Dixfield.

Councilor for three years, D. M. Stewart, South Paris.

Delegate to the Maine Medical Association Annual Session, E. M. McCarty, Rumford. Alternate, John A. Green, Rumford.

Auxiliary Committee, D. M. Stewart, South Paris.

We had the honor and pleasure of having as our guest the President of the Maine Medical Association, Dr. W. H. Bunker, of Calais. Also Dr. Joseph H. Pratt of Boston, and Drs. W. E. Webber, W. W. Bolster, and W. P. Webber of Lewiston. And the speaker of the evening, Dr. G. E. Haggart of Dedham, Massachusetts, whose subject was *Some Problems in Bone and Joint Surgery, dealing with Orthopedic problems that the general practitioner might encounter.*

Nineteen Oxford County members were present. Forty-eight members and guests partook of an excellent banquet.

J. S. Sturtevant, *Secretary.*

Penobscot

Penobscot County Medical Association Monthly Meeting, Tuesday, October 18, 1938

At 4.30 in the afternoon a demonstration of the use of the gastroscope was given at the Eastern Maine General Hospital.

At 7.30 P. M., following the monthly business meeting, a formal paper on gastroscopy was presented by Dr. I. R. Jankelson, Assistant Professor of Medicine, Tufts College Medical School.

The indications and contra-indications were discussed. The Clinical status of this newer diagnostic procedure was evaluated. Its value in the diagnosis of chronic gastritis, gastric ulcer, carcinoma, polpys and in the post-operative stomach was mentioned. The limitation of gastroscopy as compared to the comprehensiveness of the X-Ray examination was pointed out. Throughout the talk it was emphasized that the X-Rays and gastroscopy are not antagonistic but complementary diagnostic methods. The final diagnosis of gastric disease should be made by the clinician on the basis of clinical observations, laboratory studies, X-Ray and gastroscopic data. Thus, gastroscopy is only an adjunct in the diagnosis of gastric disease and does not displace any of the older methods. Some illustrative cases were cited and a number of colored pictures were shown.

Dr. C. W. McClure, Assistant Professor of Medicine, Boston University Medical School, opened the discussion by citing illustrative cases from the gastroscopic clinic at the Boston City Hospital. Forty-eight were present.

Forrest B. Ames, M. D., *Secretary.*

Piscataquis

Dr. and Mrs. R. H. Marsh of Guilford celebrated their golden wedding anniversary on October 1st. The Journal extends cordial congratulations and best wishes. Dr. Marsh is a former president of the Maine Medical Association and for 50 years has been an outstanding practitioner in his town and county.

Dr. F. L. Varney, for many years a practitioner in Monson, has retired from practice and is now living in Boston. Never a member of his County or State Associations he frequently attended the meetings of the Piscataquis County Society.

Somerset

The first fall clinical meeting of the Somerset County Medical Society was held at the Redington Memorial Hospital on September 26, 1938, at 7.00 P. M.

The meeting was called to order by President Walters of Fairfield. Under new business it was voted to hold the regular fall meeting of the Society at "Concord Haven" in Solon, as Mrs. L. J. Williams had kindly offered the use of her home for this occasion, and arrangements for this meeting to be in charge of F. P. Ball of Bingham.

The scientific program as arranged by the program committee was as follows:

Review of Peptic Ulcer, including definition, incidence, etiology and pathology by Dr. H. L. Reed of Madison.

Management and Treatment of Peptic Ulcer by Dr. G. E. Sullivan of Bingham.

Dr. R. P. Laney of Skowhegan presented a case of perforated ulcer of the stomach, covering the preoperative symptoms and post-operative findings, surgical treatment and subsequent recovery and condition at the present time.

Dr. A. J. Stinchfield presented a case of peptic ulcer in a luetic patient, which he treated by peptic ulcer management and by the use of neoarsphenamine.

Dr. Reed presented a case of lymphatic leucæmia and showed slides under the microscope to substantiate his diagnosis.

Maurice E. Lord, *Secretary.*

York

The Fall Meeting of York County Medical Society was held at the Henrietta Goodall Hospital, Sanford, Maine, October 12, 1938.

Dinner at 1.00 P. M. in honor of Dr. Bragdon who was celebrating his eighty-sixth birthday and over fifty years of practice. Every physician present told some anecdote of his medical experience.

The business meeting was held at 3.15 P. M. Dr. Cuneo was admitted to membership. It was voted to hold the next meeting at Biddeford, Dr. Paul Hill, Jr., being appointed a committee of one to make arrangements.

It was voted to bring to the attention of the Council the fact that Dr. Durgin of Eliot has been in practice for fifty years.

Dr. Bunker, the State President, spoke on: "Graduate Medical Education." He appointed Dr Kinghorn as a member of the State Committee on Medical Ethics.

There were ten members and five visitors present.

Respectfully submitted,

Charles W. Kinghorn, M. D.,
Secretary.

New Members

Aroostook

Gerald H. Donahue, M. D., Presque Isle.
Onil B. Labbe, M. D., Presque Isle.
Wilfred Brewer, M. D., Presque Isle.

Cumberland

Kenneth Dore, M. D., Fryeburg.

By Transfer:
Jack Spencer, M. D., Portland.

Franklin

Harry Brinkman, M. D., Wilton.

Kennebec

Allan C. Hurd, M. D., Gardiner.

York

Kenneth J. Cuneo, M. D., Kennebunk.

Removal Notice

G. F. Shurtleff, M. D., announces his removal from Swan's Island, Maine, to Steuben, Maine.

Notices

Dr. W. L. Holt of Scarboro is editing the Life of the late Dr. James A. Spalding of Portland, and would appreciate very much any letters by Dr. Spalding that in the owner's judgment might be of sufficient interest to put in his Autobiography. Address after November 7th will be Tucson, Ariz.

STATE OF MAINE
DEPARTMENT OF HEALTH AND WELFARE
BUREAU OF HEALTH
Augusta, Maine
October 31, 1938.

Frederick R. Carter, M. D.,
Secretary-Treasurer,
Maine Medical Association.

Dear Doctor Carter:

The Maine Dental Society, the Local Dental Societies of five towns in the State of Maine and the Division of Dental Hygiene are holding joint meetings relating to "dentistry for children." These meetings are being conducted by Drs. John Oppie McCall and Clifford J. Waas of the Guggenheim Dental Clinic, New York City.

We wish to extend to the members of the Maine Medical Association a very cordial welcome to attend any or all of these meetings as they may see fit.

The place and time of the meetings is as follows:

November 7th—Dr. McCall at Presque Isle
November 9th—Dr. McCall at Portland
November 14th—Dr. Waas at Calais
November 15th—Dr. Waas at Bangor
November 16th—Dr. Waas at Augusta

What step you can take to let the medical men in Maine know about these meetings and to extend to them a cordial invitation to attend will be sincerely appreciated.

If you desire any more information concerning these meetings please do not hesitate to ask.

Very sincerely yours,
(Signed)
Philip W. Woods, D. D. S., M. T. H.,
Director, Division Dental Hygiene.

Correspondence

MAYO CLINIC
ROCHESTER, MINNESOTA
October 24, 1938.

Dr. F. R. Carter,
Portland, Maine.

Dear Doctor:

It would be highly desirable to have the nation-wide survey of the Supply of Medical Service which is being sponsored by the American Medical Association completed within the next few months. In fact, every effort should be made to get in as many returns as possible by December 1. We are urging this in order to have statistics available at the time Congress convenes in January. The National Health Program probably will be introduced for congressional action at that time and the value of having on hand as much information as possible regarding the problems of medical care is self-evident.

We are relying upon you to use every effort to gather returns from as many counties as possible within the next few weeks. If Doctor Leland or I can be of any help to you in furthering your survey, please let us know.

Sincerely yours,

(Signed) W. F. Braasch, M. D., *Chairman,*
Committee on Supply of Medical Care
American Medical Association.

* * *

Coming Meetings*

Cumberland

Cumberland County Medical Society, Harold V. Bickmore, Portland, Secretary.

December 9th, Annual Meeting at the Eastland Hotel, 6.45 P. M.

Kennebec

Kennebec County Medical Society, Frederick R. Carter, Augusta, Secretary.

November 17th, Waterville, *Dr. Louis A. Phaneuf,* speaker.

December 15th, Augusta State Hospital, *Dr. A. Warren Stearns,* speaker.

Penobscot

Penobscot County Medical Association, Forrest B. Ames, Bangor, Secretary.

The November meeting of the Penobscot County Medical Association will be held in Bangor, Tuesday, November 15th. *Dr. Frederick T. Lord* of the Massachusetts General Hospital, Boston, will speak on *Pneumococcic Pneumonias.*

Piscataquis

Piscataquis County Medical Society, N. H. Nickerson, Greenville, Secretary.

The November meeting of the Piscataquis County Medical Society will be held in Milo, Thursday, November 17th.

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* For more detailed information regarding coming county meetings, write to the County Secretary.

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Necrologies

Herbert Hall Plumer,

1874-1938

The death on October 7th of Doctor Herbert Hall Plumer of Union marked the passing of one of the Old School Country Doctors. During his 39 years of practice in a wide area of Knox, Lincoln and Waldo counties he used snowshoes and all other possible means, when automobiles wouldn't do the job, to reach the remote homes of country folk. The distance never was too far, the way too rough, or the hour too late.

As attending physician at the Jones Private Sanitorium in Union he cared for patients from many distant parts of the State and other sections of the Country. He also lived the role of a community leader, being active in the building and maintenance of the Methodist Church, the Union Masonic block—he was an honorary member of the Lodge—the new school building and many other structures and institutions.

A member of the Knox County Medical Society, he spoke frequently before this and other groups on the care and treatment of mental disorders and associated subjects.

Born in Bucksport, October 5, 1874, son of the Rev. Charles A. Plumer (who later served as chaplain of the Maine State Prison for twenty years), and Mary Amanda Maddocks Plumer, he was graduated from Thomaston High School in 1892, attended Bucksport Seminary for a year, and was graduated from the Boston University School of Medicine in 1898. He took up his practice at Union in June, 1898, and on September 1st of that year married Alice Lenda Southworth of Thomaston, who survives him.

In May, 1937, ill health forced him to retire from his practice. Confined to his home for a year and a half after that, his death came suddenly after a brief final illness.

Surviving, besides his wife, are a brother, Willard E. Plumer of Portland, four sons, Dr. Herbert E., now of Boston, who was associated with him for a year at Union, Charles A. of New York City, Osmon B. of Gorham, Paul S. of Augusta, and three daughters, Mrs. Esther M. Kennard, Assistant Secretary of the Maine Medical Association, of Portland, Mrs. Alice Morris, a registered nurse of Boston, and Mrs. Mary Howse of Lynbrook, New York.

George W. Weeks,
1861-1938

Dr. Weeks, 77, died at his home in Cornish, Maine, September 20, 1938, after a long illness.

Dr. Weeks was born in Cornish and received his early education in the schools of that town, later attending Limerick Academy and Parsonfield Seminary. He taught school in Cornish and Scarboro for a few years, then entered Bowdoin Medical School from which he graduated in 1888. He began the practice of medicine in Limington, Maine, but in a few years he moved to Cornish where he lived the remainder of his life. In 1889 he married Miss Stella Libby of Limington, who died in 1895.

Dr. Weeks was a member of Greenleaf Lodge, A. F. and A. M. for more than fifty years, and of the Maine Medical Association. Last June he was presented a gold medal by the Medical Association for fifty years' service in his profession.

Dr. Weeks was one of "the old Type Country Doctors," not many of whom are left. He enjoyed his work and as long as he was able, he never refused a call day or night even though he knew he never would be paid. He will long be remembered for his genial manner, his humor and wit, his remarkable gift of story telling, and above all, his great kindness and understanding. These things as well as his knowledge of medicine made him beloved by the people he served.

Dr. Weeks is survived by one son, Dr. DeForest Weeks of Portland; one daughter, Mrs. Bernard Small of Cornish; one sister, Miss Effie Weeks of Portland; four grandchildren, Elizabeth Weeks, George Weeks, Estelle Weeks of Portland, and John Rufus Small of Cornish.

The following poem which was written in honor of Dr. Weeks' 75th birthday by his son seems a fitting tribute:

AT SEVENTY-FIVE

Old man, today, at seventy-five
  Gaze backward thru those years
And many a picture will arrive—
  Many a one that cheers.

How oft you've sat in dark of night
  By the bed of a suffering mother;
And by a weak and flickering light
  Brought to this world another.

How many hearts you've comforted.
  How many lives you've saved.
How hard you've worked with little thanks.
  How many storms you've braved.

Behind your horse on many a morn
  You've jogged home half asleep
To start again with scarce a yawn
  To where death's shadows creep.

Those wheels with mud well-caked you'd see,
  A horse all streaked with sweat;
Your face so tired and worn would be—
  You knew what pay you'd get.

But money is not all your pay,
  'Tis not material wealth.
It's gratitude of those, I'd say
  Whom you've restored to health.

Long hours you've driven country roads,
  In mud and snow and rain,
But if the years could be rolled back
  You'd do it all again.

I hope, when I shall reach your age,
  I, too, may also know
That I as honest service gave
  As you did long ago.

New England Postgraduate Assembly

SPONSORED BY THE MASSACHUSETTS MEDICAL SOCIETY

November 15-16, 1938—Sanders Theater, Harvard University, Cambridge

Every doctor in New England is cordially invited to attend the New England Postgraduate Assembly to be held in Boston on November 15 and 16, 1938. The speakers are all prominent educators as well as successful practitioners in their chosen fields of medicine. This is an unusual opportunity for New England physicians to obtain the latest and best information in the diagnosis and treatment of many diseases. The list of guest speakers is as follows:

Dr. Francis G. Blake, New Haven, Connecticut.
Sterling professor of medicine, Yale University School of Medicine, and physician-in-chief, New Haven Hospital.

Dr. Louis A. Buie, Rochester, Minnesota.
Professor of proctology, Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota Medical School, and chief, Section on Proctology, Mayo Clinic.

Dr. William L. Estes, Jr., Bethlehem, Pennsylvania.
Chief surgeon, St. Luke's Hospital.

Dr. Robert T. Frank, New York City.
Clinical professor of gynecology, Columbia University College of Physicians and Surgeons, and consulting gynecologist, Mount Sinai Hospital.

Dr. Alvah H. Gordon, Montreal.
Professor of medicine, McGill University, and physician, Montreal General Hospital.

Dr. Perrin H. Long, Baltimore.
Associate professor of medicine, University of Maryland School of Medicine and College of Physicians and Surgeons, and assistant physician, Johns Hopkins Hospital.

Dr. Louis H. Nahum, New Haven, Connecticut.
Assistant professor of physiology, Yale University School of Medicine.

Dr. Hubley R. Owen, Philadelphia.
Professor of clinical surgery, Woman's Medical College of Pennsylvania, and surgeon, Philadelphia General Hospital and Hospital of the Woman's Medical College of Pennsylvania.

Dr. Harvey B. Stone, Baltimore.
Associate professor of surgery, Johns Hopkins University School of Medicine, and visiting surgeon, Johns Hopkins Hospital.

Dr. Benjamin P. Watson, New York City.
Professor of obstetrics and gynecology, Columbia University College of Physicians and Surgeons, and director, Sloane Hospital for Women.

At the dinner on Tuesday evening, November 15, Dr. Warren F. Draper, assistant surgeon general of the United States Public Health Service, will speak on "Current Phases of the Problem of Medical Care." Rapid changes in the field of governmental participation in medical care make this topic one of absorbing interest, and to hear directly from a full-time governmental physician who understands the attitude of organized medicine should prove to be extremely valuable. Dr. Roger I. Lee will speak in regard to the private practice of medicine in the present social order. The dinner will be held in Memorial Hall, Harvard University, at 7.00 P. M.

The registration fee for the Assembly is three dollars; this includes admission to all sessions and to the dinner. On Tuesday, November 15, and Wednesday, November 16, luncheons will be served in Memorial Hall, Harvard University, at seventy-five cents each. Memorial Hall is in the same building as is Sanders Theater, where the assembly will be held. Reservations for luncheons must be made in advance.

PROGRAM

Tuesday, November 15

MORNING SESSION

Presiding Chairman: Dr. Frank R. Ober

10.00 Dr. Hubley R. Owen. "What Are the Duties and Responsibilities of the General Practitioner in the Treatment of Fractures? Unrecognized Fractures."
10.30 Dr. Alvah H. Gordon. "The Physician's Interest in Gallbladder Disease."
11.00 Dr. Harvey B. Stone. "Preoperative and Postoperative Preparation of Surgical Patients."
11.30 Dr. Perrin H. Long. "The Practical Interpretation of Laboratory Bacteriological and Immunological Diagnoses in Relation to Infectious Diseases."

AFTERNOON SESSION

Presiding Chairman: Dr. George R. Minot

2.00 Dr. Hubley R. Owen. "Transportation of Injured and Emergency Treatment of Fractures with Special Reference to Fractures of the Long Bones and Fractures of the Spine."
2.30 Dr. Francis G. Blake. "The Value of Antitoxin in Scarlet Fever."
3.00 Dr. Louis A. Buie. "Office Methods of Diagnosis of Anal Diseases."
3.30 Dr. Louis H. Nahum. "The Etiology and Treatment of the Cardiac Arrhythmias."
4.00 Dr. Robert T. Frank. "Endocrinology as Now Practiced."
4.30 Dr. William L. Estes, Jr. "Acute Traumatic Lesions of the Abdomen."
7.00 Dinner. Speakers, Dr. Warren F. Draper and Dr. Roger I. Lee.

Wednesday, November 16

MORNING SESSION

Presiding Chairman: Dr. Elliott P. Joslin

9.00 Dr. Francis G. Blake. "The Importance of Time in Serum Therapy."
9.30 Dr. William L. Estes, Jr. "Treatment of Open Wounds and the Use of Antiseptics."
10.00 Dr. Alvah H. Gordon. "Mental Complications in Heart Disease."
10.30 Dr. Robert T. Frank. "The Female Sex Hormones."
11.00 Dr. Benjamin P. Watson. "When is Cesarean Section Necessary and When Is Is Unjustified?"
11.30 Dr. Perrin H. Long. "The Clinical Use of Sulfanilamide in the Treatment of Bacterial Infections."
12.00 Dr. Harvey B. Stone. "Symptoms and Signs of Intestinal Obstruction."

AFTERNOON SESSION

Presiding Chairman: Dr. Arthur W. Allen

2.00 Dr. Louis A. Buie. "Treatment of Common Anal Diseases."
2.30 Dr. Alvah H. Gordon. "The Diagnosis of Diseases with Coincident Enlargement of the Liver and the Spleen."
3.00 Dr. Benjamin P. Watson. "The Treatment of Delayed Labor."
3.30 Dr. Perrin H. Long. "The Uses of Newer Derivatives of Sulfanilamide in the Treatment of Bacterial Infections."
4.00 Dr. Hubley R. Owen. "Skull Fractures and Concussion."
4.30 Dr. Louis A. Buie. "Moving Pictures."

It will greatly aid the committee if you will fill out the application blank and mail at once. Mark each space and sign your name.

Frank R. Ober, *Chairman,*
Leroy E. Parkins, *Secretary,*
Committee on Postgraduate Instruction,
Massachusetts Medical Society.

I shall attend the New England Postgraduate Assembly. Please reserve a ticket for:

Luncheon (75 cents), November 15 Yes...... No......
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PROCEEDINGS

at the

EIGHTY-SIXTH ANNUAL SESSION

of the

MAINE MEDICAL ASSOCIATION

held at

THE MALVERN, BAR HARBOR, MAINE

JUNE 26, 27, 28, 1938

SECOND MEETING

of the

HOUSE OF DELEGATES

SCIENTIFIC SESSIONS

House of Delegates

SECOND SESSION

The second session of the House of Delegates of the Maine Medical Association was held at the Malvern Hotel, Bar Harbor, Maine, on Monday afternoon, at five-thirty o'clock, with Dr. Willard H. Bunker presiding.

Chairman Bunker: The meeting will please come to order, Gentlemen.

The first order of business is the roll call by the Secretary.

The Secretary then read the roll call and the following members answered the call:

From Androscoggin County, Dr. A. W. Plummer of Lisbon Falls, Dr. W. E. Webber of Lewiston.

From Cumberland County, Dr. E. R. Blaisdell of Portland, Langdon T. Thaxter of Portland, Dr. Ralph A. Getchell of Portland, Dr. Luther G. Brown of Portland, Dr. William D. Anderson of Portland, Dr. J. C. Oram of South Portland.

From Hancock County, Dr. George A. Neal of Southwest Harbor.

From Kennebec County, Dr. Howard F. Hill of Waterville, Dr. Maurice A. Priest of Augusta.

From Knox County, Dr. C. H. Jameson of Rockland and Dr. C. B. Popplestone of Rockland; also Dr. William A. Ellingwood of Rockland.

From Penobscot County, Dr. F. B. Ames of Bangor, Dr. H. C. Scribner of Bangor, Dr. H. C. Knowlton of Bangor, Dr. H. E. Thompson of Bangor, and Dr. L. H. Smith of Winterport.

From Piscataquis County, Dr. F. J. Pritham of Greenville Junction.

From Sagadahoc County, Dr. A. F. Williams of Augusta.

From Waldo County, Dr. Foster C. Small of Belfast.

From Washington County, Dr. D. F. Bennett of Lubec.

Chairman Bunker: We have more than enough for a quorum, so we shall proceed with the business of the meeting.

The first order of business is the report of the Nominating Committee by the Chairman, Dr. Jameson of Rockland.

[Dr. Jameson then presented his written report of the Nominating Committee*, which Secretary Carter has.]

Chairman Bunker: Gentlemen, you have heard the report of the Chairman of the Nominating Committee on the Standing Committees and the Special Committees. What is your pleasure?

Dr. Webber: I move that the Secretary cast one ballot for the candidates named by the report of the Nominating Committee.

This motion was duly seconded by several of the members present, and was carried.

Secretary Carter: I have cast the ballot.

Chairman Bunker: The Secretary has cast the ballot, and I pronounce them duly elected.

Our next order of business is the election of a councilor from the third and fourth districts. Now, from the third district, which includes Knox County and Sagadahoc County, I will ask for nominations.

A Member: I nominate Dr. Ellingwood of Rockland.

Dr. Ellingwood: I think this is supposed to rotate. Dr. Kershner has pushed this over on me on two different occasions. It really belongs to Sagadahoc County; I should like to see that County represented in the district.

Dr. Kershner: Having been accused of some crime here, I think I have a right to speak in my own defense. Due to the kindness of the Knox County group, the present speaker held that position for something like twelve or fifteen years, fifteen or sixteen years, with one interruption. Sagadahoc, I am very sure, and speaking for the members that are here, is very willing that Dr. Ellingwood continue in that office, as he has so ably in the past.

Chairman Bunker: Are there any further nominations? You have already heard the nomination made and seconded for Dr. Ellingwood, as Councilor for the third district.

A Member: I move that the Secretary cast one ballot for the election of Dr. Ellingwood.

This motion was duly seconded by several of the members present, and was unanimously carried.

Secretary Carter: I have cast the ballot.

Chairman Bunker: And I declare Dr. Ellingwood duly elected as councilor from the third district.

Now, nominations are in order for councilor from the fourth district.

Dr. Hill: I nominate Carl Stevens of Belfast.

This motion was duly seconded by several of the members present, and was unanimously carried.

Dr. Williams: I move that the Secretary cast one ballot for the election of Dr. Stevens as councilor from the fourth district.

This motion was duly seconded by several of the members present and was carried.

Chairman Bunker: The Secretary has cast a ballot and I declare Carl Stevens duly elected as councilor from the fourth district.

The next order of business to come before the meeting concerns invitations for the 1939 annual session. Now, I might say, to facilitate matters, that this usually has been conducted by the council, although the House of Delegates have authority to act on this matter if they so choose. I should like to ask what is the pleasure of the House of Delegates.

Dr. Jameson: I move that that choice be left with the council.

This motion was duly seconded by several of the members present, and was carried.

Chairman Bunker: The next order of business comes under the heading of unfinished business; the reports of delegates not presented at the first meeting.

At this time, I want to call upon Dr. Ellingwood of Rockland, for his report as Delegate to the American Medical Association meeting.

[Dr. Ellingwood then presented his report as Delegate to the American Medical Association 1938 Annual Session.]

Chairman Bunker: You have heard the report given by Dr. Ellingwood of the American Medical Association meeting at San Francisco. What is your pleasure?

Dr. Webber: I move that the report of Dr. Ellingwood be accepted.

This motion was duly seconded by several of the members present, and was carried.

Chairman Bunker: The next order of business is the report by Dr. T. E. Hardy, as delegate to the Massachusetts Medical Society Annual Meeting. Is Dr. Hardy present?

[There was no response.]

As Dr. Hardy is not here, we shall go on with the report of the delegate to the Connecticut State Society.

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* Published in the July, 1938, Issue—Page 154.

[The delegate to the Connecticut Medical Society was not present.]

At this time, then, we will have to take up the reports of the Chairmen of Standing Committees who were not present at the meeting yesterday. The first is the report of the Social Hygiene Committee by Dr. E. S. Merrill of Bangor. [Dr. Merrill was not present.] Dr. Merrill not being present, we will take up the rest of the Special Committee Reports. The first is that of the Tuberculosis Committee by Dr. George Young of Skowhegan. [Dr. Young was not present.]

The next, then, is the Committee on Maternal Welfare, by Dr. Roland D. Moore of Portland.

Dr. Moore is not here, so I am going to ask Dr. Hill if he has anything to say about this.

Dr. Hill: Mr. Speaker, I am asking for the privilege of making a supplemental report to the Committee on Graduate Education. Since our report was published in the JOURNAL, I have attended a joint meeting with the Chairmen of similar committees from the other States, in San Francisco. We had a meeting of our Committee here last evening. In our report, published in the JOURNAL, we asked that the name of the Committee be changed to the Committee on Post-Graduate Education.

This whole thing is in a state of flux. That was the idea that came out last year, that this was really a committee on post-graduate education.

The Commission studying this situation, composed of representatives of the different national boards, have now come to the conclusion that the proper definition of graduate education is this: graduate education concerns the education of the practitioners from the time they get their degree in medicine until they die. Post-graduate education is when a man changes his line of work, going from one specialty to another.

Therefore, we would ask that you continue the name of Graduate Education.

On the train to San Francisco, I had the privilege of spending quite a little time with Dr. Burpee. He has been retained by the Commission studying the question of Graduate Education, as full-time worker. He told me this, which was tremendously interesting to me. He said that in his study of this problem all over the country, he found the main dissatisfaction with the practice of medicine was not the economic or financial end of it, but was a question of adequacy of medicine, which brings us back to this burning question of education.

Following the consideration of what other states are doing, your Committee, last night, went over this situation. We felt that we should continue to utilize the Christmas gifts that we have in the way of these fellowships from the Commonwealth and Bingham Funds, and that the Committee should offer our services in an Advisory capacity to the Directors of these funds. But that was not enough.

We could do one of several things. We could follow the plan now carried on, for instance, in Idaho, where they import a medical faculty and carry on an intensive course for one or two months. Or the Michigan Plan, which carries an intra-mural and extra-mural plan. Or, we could follow the plan of Tennessee, of having a traveling faculty to go around to the different sections of the State, majoring in one subject and offering a certificate issued by the State Medical Association, after a man has completed that course.

Or, we could adopt the Massachusetts plan of a traveling circus. Now, I hope nobody from Massachusetts will object to that term, but that is what it is.

Our feeling was that in Maine, with our own particular problems and our geographic distribution, we could advise this body that a comprehensive extension program be made up, through the medium of the county societies, taking our already existing bodies, and that our Committee would coöperate with the county officers in putting on a program which would be comprehensive in an educational way, perhaps going into the basic fundamentals to a certain extent; also that we would not suggest the exclusion of local presentations, feeling that the opportunities of presenting and reading papers by our own men was a valuable educational feature.

Now, in order that this may be done in a statewide way and in an equitable manner for all of our county societies, we have the temerity, Mr. Speaker, to ask for an appropriation of $500.00 for the coming year, which can be used to help out this rounded program for certain counties that might need it.

It is our idea to procure information and meet with the county secretaries at the fall session, and try to suggest a comprehensive educational program.

Now, in addition, the Committee is going to be in a position to furnish information regarding post-graduate or graduate courses, to any members of the association who wishes it. We would like to make it a personal thing; each member of the Committee is to be ready to answer questions regarding any post-graduate information in any way, and in every way possible.

That is the burden of our report, Mr. Speaker.

Chairman Bunker: That is simply a report. Did you wish to make any recommendation?

Dr. Hill: We have asked for $500.00.

Chairman Bunker: I mean, do you expect this House of Delegates to authorize you to spend $500.00?

Dr. Hill: We would like it.

Dr. Knowlton: I so move, that we do authorize the expenditure of $500.00 for graduate education work.

This motion was duly seconded by several of the members present, and was carried.

Chairman Bunker: The next order of business is the report of the Reference Committee, by Dr. H. E. Thompson.

Dr. H. E. Thompson: The Reference Committee has had two subjects referred to it for consideration. The first was a suggestion by Dr. Hill that the retiring President be made ex-officio a member of the Council.

The Reference Committee recommends that the suggestion which Dr. Hill made to the House of Delegates, relative to the advisability of changing the make-up of the Council so as to include the immediate past-President an ex-officio member for one year following his term of office, be accepted by the House of Delegates.

Mr. Chairman, I move that the House of Delegates adopt the suggestion of Dr. Hill.

This motion was duly seconded by Dr. Webber and several other members present.

Dr. Williams: In adopting this resolution as it has been presented, isn't that opposed to our Constitution? I believe a year has to elapse before we can pass such a resolution.

Dr. Hill: Mr. Speaker, I think that Dr. Williams is perfectly right; this will probably have to be acted upon next year.

Dr. H. E. Thompson: I will make a motion, then, that the article referred to be amended so that this motion may be included as an amendment to the Constitution. I think that will clarify the matter.

This motion was duly seconded by several of the members present, and was carried.

Dr. H. E. Thompson: The Committee had one other matter referred to it, in the form of a resolution, by Dr. Hill, that staff appointments in hospitals, should be determined by a governing board of the hospital, in coöperation with the active professional staff. It is advised that this be accomplished by consultation with a committee representing the active staff. The Committee had considerable discussion, and, after listening to various recommendations, we wish to present the following:

Staff appointments in hospitals should be made by the governing board from recommendations made by the active professional staff. Only such appointments shall be made as are mutually acceptable to the majority of the full governing board and a majority of the full, active, professional staff. Such appointments shall be made from members in good standing of the Maine Medical Association. Exceptions shall be made to government hospitals, private hospitals and hospitals maintained by a religious order.

This form met the unanimous approval of the Committee and therefore, I move that this resolution be adopted by this House of Delegates.

Dr. Webber: I wish to second that motion.

Chairman Bunker: Gentlemen, you have heard this resolution, which has been duly seconded. Is there any further discussion?

Dr. Hill: May I have the privilege of discussing this again, having presented the original resolution, as a member of the hospital committee that met in conjunction with a similar committee from the Maine Hospital Association. Perhaps our wording could have been better. Our joint Committee suggested staff appointments in coöperation with the active staff. Our feeling was that this should be accomplished by a committee representing the staff. Perhaps we should have said a committee elected by the staff.

Now, we have got to make this coöperation felt. This resolution is a perfectly fine one, from our point of view, but even if it is adopted by this Association, it carries no weight. It has got to be taken up with the Maine Hospital Association.

It was suggested yesterday that we adopt a pugilistic attitude, which I hope will not maintain, because at the meeting of the State Hospital Association, there was incorporated into its Constitution and By-Laws last year, a provision that the appointment to the staff should be limited to the regular, practitioners, graduates in medicine, M. D.'s. Now, I believe that is going to be a valuable item for us.

With reference to the hospitals, I might say that the Trustees of the hospitals are the representatives of the invested funds of the hospital and of the public, and in this resolution, as changed by the Reference Committee, it takes away from the Trustees all initiative power; you have got to remember that.

In other words, as I see it, after hearing it read, it means that all staff appointments must initiate from the active staff, and an occasion might arise, as anyone can see, whereby a staff might be comatose, complacent, and yet there would be obviously a need for the infusion of new ideas and new blood, but according to this resolution, no change could be initiated, except when it came from the staff.

I doubt if the Trustees of the Maine Hospital Association would accept such a resolution, but it might be tried out in conference.

Dr. Webber: Mr. President, this is a meeting of doctors, for the doctors and by the doctors, and this is not a meeting of a hospital association.

It becomes essential for the doctors to defend themselves and to stand on their own feet. Let me give you a little history. I have been in this work for forty-five years. I know it is a sign of old age to reminisce, but I am going to tell you a little something to see if it doesn't correspond to your own situation, wherever you may be.

The hospital in Lewiston was founded by doctors. The doctors called in a group of incorporators, who were to elect a group of directors to run the economic side of the hospital, with no idea of the directors ever interfering with the medical side of the hospital.

Now, the rule was that the staff should originate from the staff and the directors should elect the staff.

It happened early in the career of the hospital that the doctors wanted a certain man who was probably at least considered by the physicians the best equipped man for the place, to take a position on the surgical staff; the directors of the hospital, because of the enmity, particularly, of the President of the then directors of the hospital refused to confirm the nomination. Ultimately, the staff appointed another man, and he was confirmed by the directors.

Now, the thing runs along in a smooth channel, with splendid coöperation between the men.

I think that it is well known throughout the State that the conditions in Lewiston and Auburn were particularly favorable to the doctors, and that they were advancing as fast as it was physically possible for the men in their position to advance and struggle along to the best of their ability.

The idealism of the doctor is such that he doesn't pay much attention to the political side of the thing unless it presses upon him hard. He is anxious for the safety of his patients and he is anxious to improve his own knowledge and his own ability to take care of his patients. He is altruistic enough to think that the other men who are pressing into hospital work are cognizant of that fact, and consequently he lets the thing drift. The result is that in the course of years, the original men on the board of directors pass away, and the directorate is slowly changed.

Now, let me tell you this. The directorate of a hospital is a closed corporation. You can't elect a man to the directorate of any hospital in this State, except when he is accepted by the directors who are there; they nominate him and they elect him. Why? Nobody wants the job, and nobody will accept the job under the competition, and consequently you can't go in and elect a director in competition with the men whom these fellows have picked out. They pick him out, too, believe me.

Now, you go along in years as we did, until you fall into the hands of some men who think they know more about medicine than the doctors themselves. They immediately begin to give trouble to the doctors. They bring in men from outside; they don't care anything about the staff.

That is what is going to happen to every one of you in all of your hospitals, unless you do get together and stand together, so that you, as doctors, are going to nominate your own staff. Dr. Hill says that the doctors might get into such a position that they would refuse anybody to come in. Now, that might occur in Boston, possibly, where you have got a big city and where there is a lot of competition, but I don't believe it has ever occurred in Lewiston, and I don't know that it has ever occurred anywhere else in Maine, that a first-class man who came in to your community and was there long enough for your men to know him, was ever refused admittance to the hospital. Such men have always worked up, in time, to the position to which they are entitled. Of course, a man can't expect to come in and replace the older man, all in one jump.

Of course, you can't pick out any body of men that doesn't have its "lame ducks."

In this instance, we have got to defend ourselves by taking a stand that we believe the doctors ought to choose their own membership in the hospitals. Believe me, Gentlemen, that is essential, and if you don't believe it, you will find it out so that you will believe it before a great while, because this thing is spreading.

This isn't a local issue; this is an issue all over this country, and the doctors in other places have taken active steps along the same lines, and I'll say they have taken much more active steps than this one.

This resolution simply notifies the Hospital Association that as doctors, we believe that doctors know who should be chosen to take the places in the hospitals; who is better fitted or anywhere near equally fitted to pick out the men who should take charge of your hospitals? I can't believe that any of you think anything except that the doctors should do that thing, and when they refuse, as Dr. Hill says they do, to accept the nomination from the staff, that shows you the drive of the current, and that shows you what they are going to do. They are going to kick you down hill, unless you stand up and go ahead and make yourselves known to them and tell them that this is what is necessary to be done and that this is what you believe should be done. I don't think there is one among you but does not believe that the doctors are the best judges of who should fill those places. I don't believe there is one among you who doesn't think that this thing is a perfectly just thing to be put up and to be carried through.

I don't think that you need to be alarmed any, in regard to the attitude of any hospital association that ever existed. The fact is, really, that it is a similar proposition to your State Police; it isn't the arrests that they make, but it is the fact that the State Police are on the road and they are on the heels of you and me and the other fellow to keep our speed down and to keep us from committing all sorts of road violations that we might be committing without the State Police.

Now, these hospital association fellows are, as a rule, old, retired men, who have had more or less success in life, and who believe that they know more about the thing than any group of doctors they know of. When they know that we stand together, as a unit, and when they know that we believe the doctors should nominate the staff and should have the say in the matter, I know they would listen to us, and they would do that for us.

The directorate in our hospital discovered that they had a considerable fight on their hands, and they backwatered quite a good deal. These hospital association fellows will do the same thing.

But they will hold their own just as long as they think we will stand for it. Let us have a united front, all of us, in this matter.

Chairman Bunker: Is there any further discussion on this resolution, before it is presented for a vote?

Dr. Hiebert: Mr. Chairman, I am not a delegate here, but I have the honor to be President of the Maine Hospital Association. I am a physician, and I find myself very often in the place where I must interpret between boards of trustees and physicians.

I would say this without any mental reservation. I believe in the present form of medical practice, and I will do and plan to do everything I can to preserve it. I think that the Maine Hospital Association feels exactly the same way. We have gone on record to coöperate with the body, without whom there could be no hospitals.

This afternoon, however, in listening to the resolution as presented by Dr. Thompson, I noticed class legislation or suggested class legislation. If it is good to exclude private hospitals and religious hospitals and government hospitals and state-owned hospitals from this resolution, then it seems to me that all the other hospitals should be excluded, also. If this resolution is particularly good for hospitals, then this organization should have no right to give hospitals, like the Central Maine General or the Maine General in Portland, a beneficent legislation. I am very certain that the Trustees of the hospital, of which I have the honor to be superintendent, will plan to coöperate with the medical association in providing the best possible care for patients.

The prerogative, as expressed in the original resolution presented by Dr. Hill, is one guarantee to trustees of public institutions by the Constitution of the State of Maine. I do not think that we should take any rights away from organized hospital practices.

In conclusion, let me state this as a matter of fact, because I know it to be true, that in the Lewiston Hospital, there are not now, and neither have there been at any time, any appointments to the staff which were not recommended by a Committee appointment.

Dr. Knowlton: There is a question of the set-up at Bangor at the moment, but that will be guaranteed by this resolution, if the resolution could be clearly enforced.

Staff appointments are given to the Board of Trustees for their consideration, and they are backed by the Service involved, and then they go back to the Trustees for final appointment. Now, part of what Dr. Webber says interests me. In Lewiston, undoubtedly the doctors did start the hospital years ago, but they gave up some of their rights and then apparently they took them back again. It was a struggle and an awful bother and quite a few people's feelings got hurt. But they got their rights back again. I think that is the way to handle the matter. We considered such a thing last year and turned it down. These things are, after all, problems in local democracy, and it seems to me that they should be worked out on that basis. I don't believe that twenty-five or thirty men can legislate for the Association.

If they find legislation binding upon them personally, it doesn't amount to anything anyway.

Dr. Thaxter: As I understand it, are private hospitals excluded?

Chairman Bunker: Yes, I think so.

Dr. Thaxter: Then what is a private hospital, anyway? Is the Central Maine Hospital a private hospital?

Chairman Bunker: It is classed as a voluntary hospital. It is endowed as a private corporation and has its Board of Incorporators, from which the Board of Directors is elected annually.

A Member: I can't see that this resolution, although I worked on this Committee, offers anything but what has always existed in the hospitals here in Maine, that the staff appointments originate with the staff, and are approved by the Board of Directors. That is essentially what has always existed here. I can't see that there is any change. I really can't see any reason why there should be any change.

Chairman Bunker: Gentlemen, is there any further discussion on this question.

Dr. Plummer: Do I understand that this resolution says that no appointment shall be made except from members of the Maine Medical Association?

Dr. Thompson: Members in good standing.

Dr. Plummer: Am I correct in understanding it so?

Dr. Thompson: Yes.

Dr. Plummer: Then I move, Mr. Chairman, that the resolution be amended by striking out that clause. And I should like to make a remark on that matter. Well, I guess I won't.

Chairman Bunker: A motion has been made that the present resolution be amended by striking out—well, will you repeat your motion again, Dr. Plummer?

Dr. Plummer: I move, Mr. Chairman, that that clause, I can't word it, but I refer to the clause that makes the requirement that these appointments shall be made only from members of the Maine Medical Association; I move that that be stricken out. I would like to say a word on that, too, if it is permissible.

There was some talk in the papers, after the meeting of the American College of Physicians in New York, to the effect that some members of the A. M. A. might even go so far as to start a new association. Now, I don't have much idea that that would be done, but it might be done, and if it should be done, there might be another organization started in this State. On the other hand, too, there are some men in the State who are not members of the State Association.

Now, if the prime objective is just to do something for the State Association, why, that is all right. But, if we are trying to do something for the medical profession as a whole, particularly in its relation to the general public welfare, which can be its only proper objective, I don't see why we should exclude any from the opportunity to become members of the staff of any hospital, if it was agreeable to the staff and to the directors of the hospital, whether they are members of the Association or whether they are not.

If we try to get a monopoly of this thing, that may be all right, but personally, I have considerable opposition to a monopoly, even as in the present case.

I think it is a mistake, Gentlemen, and furthermore, you are inviting opposition.

When the public learns about this resolution, they will think that we put it through for the welfare of a closed corporation. They will overlook, and in fact they probably don't know much of anything about the condition that may have existed or might exist in a hospital, so far as any friction between the directors and the staff is concerned. They will say: "Here is an effort to shut out any who are not members of the Maine Medical Association."

I think it is a mistake, Gentlemen, to include that clause in this resolution. It would be better if we amended that resolution, by striking out that clause, and then vote on the main proposition.

Chairman Bunker: Does the Reference Committee accept that amendment?

Dr. Thompson: I don't think the Reference Committee would quarrel very much over that particular part of it.

Chairman Bunker: Then, the Chairman of the Reference Committee does accept that amendment?

Dr. Thompson: Yes.

Chairman Bunker: Will you read the resolution again, Dr. Thompson?

Dr. Thompson: "Staff appointments in hospitals should be made by the governing board, from recommendations made by the active, professional staff. Only such appointments shall be made as are mutually acceptable to a majority of the whole governing board and a majority of the whole active, professional staff."

Then, according to the amendment, we strike out practically all the rest of it. The part we strike out is this: "Such appointments shall be made from members in good standing of the Maine Medical Association."

The exceptions will be made to government hospitals, private hospitals and hospitals maintained by a religious order.

Dr. Knowlton: I believe it should be: "Hospital appointments should be made," whereas you have a "shall" in there. It would be something to be desired, I believe.

Dr. Thompson: The first one is "should" and the second one is "shall."

Dr. Knowlton: Then I would suggest that you change the "shall" and it will be fine. If that is done, then we have something to be desired.

Dr. Thompson: I think the Committee would be perfectly agreeable to change the "shall" to "should" and have the word "should" in both cases.

Chairman Bunker: You gentlemen have heard the question under discussion and the resolution as amended. We shall now vote on the resolution, as amended, which has just been read.

Dr. Ellingwood: I wonder if anybody would like to discuss what Dr. Brown mentioned concerning the exceptions. I don't know what they mean by "religious hospitals," exactly. As to government hospitals, we have no jurisdiction over them anyway, I guess. Private Hospitals don't have a staff.

Chairman Bunker: We have no jurisdiction over government hospitals; that is correct.

If there is no further discussion, all those in favor of the resolution as amended, will please manifest by raising the right hand. [Eleven hands were raised.] Those who are against the resolution will please manifest by raising the right hand. [Six hands were raised.]

Chairman Bunker: The vote is carried, and the resolution, as amended, is accepted.

Now, gentlemen, according to our Constitution and By-Laws, the question raised in regard to the addition of the President as an ex-officio member of the Council cannot be decided at this time. It will, necessarily, have to be decided at the next meeting of the House of Delegates, which could not come under two months.

Dr. Plummer: Mr. Chairman, I would like to make a suggestion. I don't think any member of the House of Delegates or any member of the Association would raise objection, if the spirit of the suggestion were adopted by making the outgoing President virtually a member of the Council.

Chairman Bunker: It necessitates an amendment to the Constitution.

Dr. Plummer: Yes, officially, but as I say, I doubt if any objection would be raised if he exercised all the functions that he would, were he a member, except, possibly, the privilege of voting in the meetings. I doubt if anybody would raise objections to that.

Dr. Carter: You mean to enter discussions and things of that sort?

Dr. Plummer: Yes.

Dr. Carter: The President may do that, of course.

Chairman Bunker: Is there any further business to come before this meeting of the House of Delegates? If not, a motion to adjourn is in order.

Dr. Thompson: I move that we adjourn.

This motion was duly seconded by several of the members present, and was carried.

[Whereupon, the Second Meeting of the House of Delegates was adjourned at seven-fifteen o'clock in the evening.]

SCIENTIFIC SESSIONS

The Scientific Sessions of the Maine Medical Association were held in the Ball Room of the Malvern Hotel, Bar Harbor, Maine beginning on Monday, June 27, 1938, at two o'clock in the afternoon, with President Wakefield presiding.

President Wakefield: The meeting will please come to order, Gentlemen.

This is the first opportunity I have had to welcome you to Bar Harbor. We hope that you will all get located and that you are comfortably situated, and also that you will enjoy the program. We also hope that you will allow us to be your host again sometime.

I think it was more than twenty years ago when the Maine Medical Association first came to Bar Harbor. At that time, we elected Dr. Eben Bennett of Lubec, President. We saw in the paper this morning where Dr. Bennett has celebrated his ninetieth birthday, and Secretary Carter has sent him a telegram of congratulations. I know that you will heartily approve of that. He is one of our grand old men, an ex-President of the State Association.

The Ladies' Tea will be given this afternoon, and if anyone wants to tell their wives about it, it will be held at the Shore Club this afternoon, at four-thirty.

If Dr. Bunker will now take the Chair, I will give my address.

[Dr. Bunker then assumed the Chair.]

Chairman Bunker: Gentlemen, it is with much pleasure that I have the opportunity to present our President, Dr. Wakefield, for his Annual Address. [Applause.]

[Dr. Wakefield then read his prepared address.]

Chairman Bunker: Gentlemen, I am sure that we have all enjoyed the paper which was so ably presented by Dr. Wakefield.

I wonder if the members present have anything to offer in the way of discussion. If not, I shall turn the meeting back to Dr. Wakefield.

[Dr. Wakefield then assumed the Chair.]

President Wakefield: Gentlemen, I feel that we have a very interesting program this afternoon.

A Symposium will be presented on Acute Respiratory Infections. There will be two papers presented, with reference to the upper and lower respiratory infections, before we have any discussion.

The first paper to be presented this afternoon will be on the subject of "Upper Respiratory Infections," by Dr. Frederick T. Hill of Waterville, a Past President of this Association. [Applause.]

[Dr. Hill then read his prepared address on the above subject.]

President Wakefield: Gentlemen, I am very sure that we have enjoyed this very interesting paper by Dr. Hill.

We are going to hear the next paper on "Lower Respiratory Infections," by Dr. Donald King of Boston, before we have the discussion.

It gives me great pleasure to present Dr. King of the Massachusetts General Hospital, Boston. [Applause.]

[Dr. King then presented his paper on the above subject.]

President Wakefield: I think I can assure Dr. King that the Maine Medical Association is very grateful for his coming up from Boston and presenting this very, very able paper. I know we have all enjoyed it immensely.

We will now discuss these respiratory infections, and the discussions will be limited to five minutes.

Dr. Hill's paper will be discussed by Dr. R. M. McQuoid of Bangor.

[Dr. McQuoid then read his prepared discussion.]

President Wakefield: Is there any other discussion on Dr. Hill's paper? If not, have you anything further to say in addition, Dr. Hill?

Dr. Hill: I only wish to say that this is a joint paper by Dr. Irgens and myself.

President Wakefield: Dr. Charles Steele of Lewiston will now discuss Dr. King's paper.

President Wakefield: Thank you, Doctor. This paper is now open for general discussion, Gentlemen.

[Discussed by Dr. Pratt and Dr. Piper. Discussion closed by Dr. King.]

President Wakefield: Ladies and Gentlemen, the next subject in our Symposium will be "Pneumonias of Infancy and Childhood," by Dr. J. L. Wilson of Detroit, Michigan.

[Dr. Wilson then presented his prepared paper on the subject.]

[At this point, Dr. Bunker assumed the chair.]

Chairman Bunker: We are, indeed, grateful to Dr. Wilson for traveling so far and giving us such a fine talk.

I am going to ask Dr. Merrill S. F. Greene of Lewiston to open the discussion on this paper.

President Wakefield: I shall call for any further discussion on Dr. Wilson's paper.

[Discussed by Dr. Foster. Discussion closed by Dr. Wilson.]

President Wakefield: Again, I want to take this opportunity to thank Dr. Wilson.

The next paper in our Symposium is the "Surgical Treatment of the Complications of Pneumonia," by Dr. Edward D. Churchill of the Massachusetts General Hospital of Boston.

[Dr. Churchill then read his prepared address on the above subject.]

President Wakefield: Discussion of this paper will be opened by Dr. George Young of Skowhegan.

President Wakefield: Is there any further discussion on Dr. Churchill's paper? If not, Dr. Churchill, do you wish to say anything further, in closing the discussion?

[Discussion closed by Dr. Churchill.]

President Wakefield: This concludes our scientific program, Ladies and Gentlemen. I think we are all agreed that this has been one of the best we have ever had. I have enjoyed it and I know all of you have.

If any of the speakers or visitors would like to withdraw at this time, they can, although we would be glad to have everyone stay.

The next order of business on our program is one of the most important things we do; we are going to vote on our President-Elect. I am going to call upon Dr. Nichols at this time for his report.

Dr. Nichols: Mr. President and Gentlemen of the Maine Medical Association. I wish to present the name of George L. Pratt of Farmington. I would simply say that he has the unanimous support of all the physicians of Farmington and of Franklin County. Incidentally, I might tell you that Franklin County has never had a President of this Association; not that we put that in as a reason for selecting Dr. Pratt, because we want to put him in on his merits alone.

The fact is, you all know him almost as well as I do. But I want to say that he is a mature-minded man; he is a clear thinker. For years and years, he has kept our Franklin County Medical Association in working order, as its Secretary and Treasurer, and he has a thoroughly good knowledge of the work of the Maine Medical Association. He has a knowledge of its problems. I think if we elect him, we will be electing a safe and sane leader. [Applause.]

Dr. Gehring: Mr. President and Members of the

Maine Medical Association. It has been my privilege to know Dr. Pratt for thirty-two years, and to watch his career throughout that time. I can assure you, if you don't already know it, that by virtue of his age, his experience, his ability, his common sense, his character and his dignity, and last, but not least, his loyalty to this institution, qualify him absolutely for the duties which evolve upon the President-Elect or a President. And, more than all of that, his record in the Association entitles him to the honor which this election would bestow upon him.

It is a pleasure, yes, it is a great pleasure, and I am proud to second Dr. Nichols' nomination of Dr. Pratt for President-Elect of this Association. [Applause.]

A Member: I move that the nominations be closed, and that the Secretary cast one ballot for the election of Dr. Pratt of Farmington as President-Elect of this Association.

This motion was duly seconded by several of the members present, and was carried.

Dr. Carter: I have so cast the ballot.

President Wakefield: And I declare Dr. Pratt duly elected as President-Elect of this Association. [Applause.]

Dr. Pratt: I appreciate deeply the vote of the assembly, Ladies and Gentlemen. You have elected some fine men in the past, and they have set a standard, which I shall try to follow. I can only say that I will do my best. I thank you all very much. [Applause.]

President Wakefield: You heard me say at the beginning of this meeting that our Secretary sent a telegram to Dr. Bennett, to congratulate him on his ninetieth birthday. We have received a message, in answer to Dr. Carter's telegram, as follows:

> "Congratulations appreciated. Highest hopes for the best meeting ever. E. H. Bennett." [Applause.]

President Wakefield: This concludes the program of the afternoon. I want to announce that there will be a meeting of the House of Delegates immediately following this meeting, at 5.30 p. m.

A Member: I move that we adjourn.

This motion was duly seconded by several of the members present and was carried.

[Whereupon, the Monday Afternoon Scientific Session was adjourned at five-twenty o'clock in the afternoon.]

TUESDAY AFTERNOON SCIENTIFIC SESSION

June 28, 1938

The Tuesday Afternoon Scientific Session of the Annual Meeting of the Maine Medical Association was held on June 28, 1938, in the Ballroom of the Malvern Hotel, Bar Harbor, Maine, at two-fifteen o'clock in the afternoon, with President Wakefield presiding.

President Wakefield: The meeting will please come to order, Ladies and Gentlemen.

The first order of business on our program this afternoon is a paper by Dr. Adam P. Leighton of Portland, on the subject of "The Low Transverse Cervical Cesarean Section."

[Dr. Leighton then presented his prepared paper on the above subject, with lantern slides.]

President Wakefield: Dr. Leighton has given us a very plain, concise and interesting idea of the low transverse Cesarean section, which I know we have all enjoyed.

Now, before this paper is discussed, I have promised to allow two men to speak very briefly to us. The first is Mr. Young, who wants to tell us very briefly about hospital care insurance matters.

Mr. Young: Mr. President and members of the Maine Medical Association. I want to talk to you for a few moments on the subject of hospital care insurance plans. A great many of you men have already heard about this, I am sure. Similar plans are in existence in many of the large cities. The American Hospital Association has approved some forty-odd plans in as many cities, and enrolled under those plans there are today over 2,000,000 subscribers.

First, I am going to say that hospital care enables persons of moderate means to budget their hospital bills and this has the effect of stabilization and increasing revenue from hospital patients, because few persons can tell when they will need hospital care or what the cost will be. Individuals and families have found it difficult to budget hospital care in the same way that they have other necessary items, such as food, clothing and shelter. But, a group of individuals can accomplish what would be impossible for any one of them, acting alone, to accomplish.

The total cost of hospital care for a group can be accurately estimated. Each of the group make regular and equal payments to a common fund, which is used for the purchase of hospital care, as it becomes necessary for those in the group. This procedure of group budgeting is merely the application of the principle of insurance to the payment of hospital bills, of which neither the amount nor the time can be predicted by the sick persons.

Hospitals should be coöperative rather than competitive institutions. For this reason, the American Hospital Association does not recommend the establishment of more than one non-profit insurance plan in each community. Too much emphasis cannot be placed upon the opportunity for all the hospitals in the community to participate in the non-profit plan. A subscriber should be free to choose his hospital at the time of illness.

This movement, which will reach approximately 10,000,000 people in the next five years, requires the

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hospitals to assume the responsibility for the lowest possible rates to subscribers, and for the efficient service within that institution that they choose.

Now, as I have said before, the American Hospital Association have approved some forty of these plans. How many cities are really covered by the plans, I can't tell you, but there are a great many more than that. Some plans cover as many as eight and ten cities.

We have organized here in this State, the Associated Hospital Service of Maine, for the purpose of providing this hospital insurance to groups of individuals, employed groups; those groups with border-line incomes; those who find it difficult to pay a hospital bill, a doctor's bill and all the other extra expenses that go along with it.

I am just going to repeat again that hospital care insurance enables persons of moderate means to budget that expense and has a tendency to stabilize and increase the revenue from hospital patients. I know that my time is up now, but I want to thank you gentlemen for the time that you have given to me. [Applause.]

President Wakefield: The paper of Dr. Leighton will now be discussed by Dr. T. S. Stevens of Portland.

[Discussion closed by Dr. Leighton.]

President Wakefield: The next paper on the program, Ladies and Gentlemen, will be by Professor John R. Fraser of McGill University, Montreal, Canada. Dr. Fraser will speak to us on the subject of the "Control and Management of Puerperal Infection."

[Dr. Fraser then presented his prepared paper on the above subject.]

President Wakefield: I know that this audience was impressed by this wonderful paper by Dr. Fraser. We certainly want to thank him for coming from Montreal to give us this fine address.

This paper will now be discussed by Dr. Walter F. W. Hay of Portland.

President Wakefield: Is there any other discussion on this paper? If not, I am going to ask Dr. Fraser to close the discussion on his paper.

President Wakefield: Our next speaker will be Dr. Fuller Albright of the Massachusetts General Hospital of Boston. His subject is "Endocrinology in Relation to Obstetrics and Gynecology."

[Dr. Albright then presented his prepared paper on the above subject.]

President Wakefield: I think that this is a very interesting subject.

Dr. Henry Knowlton of Bangor will now open the discussion of Dr. Albright's paper.

[Discussion closed by Dr. Albright.]

President Wakefield: The last paper of the meeting and of the session will be on the subject of "Medical Publicity," by Dr. Frank H. Jackson of Houlton. [Applause.]

[Dr. Jackson then presented his prepared paper on the above subject.]

President Wakefield: Dr. Jackson's paper will be discussed by Dr. Piper of Waterville.

President Wakefield: Gentlemen, this concludes the assigned papers of the session. I think you will agree with me that they have been particularly high-class.

President Wakefield: There are two announcements that I wish to make. I hope you will all stay to the banquet tonight, where you will hear Dr. Lahey speak again.

There will be a meeting of the Council immediately after this meeting.

President Wakefield: If there is no further business to come before the meeting, a motion is in order to adjourn.

Dr. Knowlton: I move that we adjourn.

This motion was duly seconded by several of the members present, and was carried.

[Whereupon, the Second Scientific Session of the Annual Meeting of the Maine Medical Association, was adjourned at five o'clock in the afternoon.]

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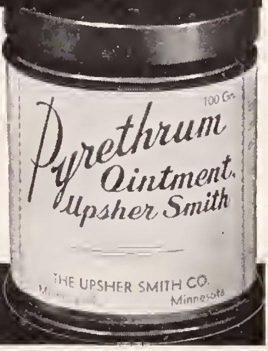

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Book Review

"The Management of Fractures, Dislocations, and Sprains"

By John Albert Key, B. S., M. D., St. Louis, Mo., Clinical Professor of Orthopedic Surgery, Washington University School of Medicine; Associate Surgeon, Barnes, Children's, and Jewish Hospitals and

H. Earle Conwell, M. D., F. A. C. S., Birmingham, Ala., Consulting Orthopedic Surgeon to the Tennessee Coal, Iron & Railroad Company, and the Orthopedic and Traumatic Services of the Employees' Hospital; Associate Orthopedic Surgeon to the American Cast Iron Pipe Company; Attending Orthopedic Surgeon to the Crippled Children's Hospital, St. Vincent's Hospital, South Highlands Hospital, Hillman Hospital and Children's Hospital, Birmingham, Alabama. Member of the Fracture Committee of the American College of Surgeons, American Academy of Orthopedic Surgeons and the Advisory Fracture Committee of the American Medical Association. Second edition. Published by the C. V. Mosby Company, 1937. Price, $12.50.

The second edition of this monumental work of 1246 pages and 1222 very excellent illustrations has been added to considerably, especially in the section on the treatment of fractures of the spine and hip. The chapters on Skull Fractures and Brain Trauma have been revised by Dr. Edgar F. Fincher for the late Dr. Dowman. The chapter on Fractures of the Face and Jaws was revised by Dr. James Barrett Brown.

It seems that everyone, medical student, physician or surgeon, who might be confronted with first aid duty as well as subsequent service on accidental injuries of the bony frame of the human body, would like to have this excellent textbook as his reliable consultant and always remember that "the physician's record should include a brief account of the accident, the chief symptoms, the subjective and objective findings and the diagnosis as made at the first examination, the treatment rendered with dates, important changes in the patient's condition and the final diagnosis and the end-result." This, together with a reasonable knowledge of a great many possible fractures, a knowledge of the methods of treatment, a reasonably complete supply of appropriate supplies as depicted and described by the authors, a reasonable amount of technical and surgical skill, should render the care and treatment of fractures, etc., very successful, both functionally and structurally.

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NARCOLEPSY

Ulrich, H.: Narcolepsy and Its Treatment with Benzedrine Sulfate—New Eng. J. Med., 217:696, 1937.

GASTRO-INTESTINAL EFFECTS

Myerson, A. and Ritvo, M.: Benzedrine Sulfate and Its Value in Spasm of the Gastro-Intestinal Tract—J.A.M.A., 107:24, 1936.

POST-ENCEPHALITIC PARKINSONISM

Davis, P. L. and Stewart, W. B.: The Use of Benzedrine Sulfate in Post-Encephalitic Parkinsonism—J.A.M.A., 110:1890, 1938.

DEPRESSION

Wilbur, D. L.; MacLean, A. R. and Allen, E. V.: Clinical Observations on the Effect of Benzedrine Sulphate—J.A.M.A., 109:549, 1937.

Woolley, L. F.: The Clinical Effects of Benzedrine Sulphate in Mental Patients with Retarded Activity—Psych. Quart., 12:66, 1938.

MISCELLANEOUS

Reifenstein, E. C., Jr. and Davidoff, E.: The Treatment of Alcoholic Psychoses with Benzedrine Sulfate—J.A.M.A., 110:1811, 1938.

Hill, J.: Benzedrine in Seasickness—Brit. Med. Jour., ii:1109, 1937.

Lesses, M. F. and Myerson, A.: Human Autonomic Pharmacology. XVI. Benzedrine Sulfate as an Aid in the Treatment of Obesity—New Eng. J. Med., 218:119, 1938.

Present Status of Benzedrine Sulfate — Report of the Council on Pharmacy and Chemistry — J.A.M.A., 109:2064, 1937.

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III. Some Attainments in the Fields of Vitamin A Research

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Physiological and clinical researches have provided explanations of the mode of absorption of the vitamin and the mechanisms of transport and storage in the body (2). The specific pathological effects of varying degrees of vitamin A deficiency in humans have been extensively studied. Many of the older ideas concerning specific effects of vitamin A on man have been confirmed; some of the older beliefs have been dispelled (2).

Recent years have also brought improvements in assay methods for vitamin A (3). Common American foods have been surveyed and their vitamin A values tabulated (4). Last but not least, authoritative estimates are at hand as to the quantitative requirements of children and adults for vitamin A (5). Such, in brief, are only a few of the important additions which have been made to our knowledge of this essential dietary factor. Today, students of nutrition favor the practice of "protective nutrition" in which the individual is maintained upon a diet calculated to supply all known dietary essentials—vitamin A included—in optimal amounts insofar as these amounts may be known. In specific instances, such dietaries must be supplemented by vitamin-rich materials. However, the prime consideration is to provide a properly formulated basic diet. In this connection, commercially canned foods are worthy of mention.

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1. 1938. J. A. M. A. 110, 1748.
2. 1938. Ibid. 111, 144.
   1938. Ibid. 110, 2072.
3. 1938. Ibid. 111, 245.
4. 1937. U. S. D. A. Bur. of Home Econ., Misc. Pub. 275.
5. 1934-1935. Amer. Pub. Health Assn. Year Book 25, 69.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the forty-second in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.

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Glisson, writing in 1671, described an ingenious use of swaddling bands — "first crossing the Brest and coming under the Armpits, then about the Head and under the Chin and then receiving the hands by two handles, so that it is a pleasure to see the Child hanging pendulous in the Air . . . This kind of Excercise . . . helpeth to restore the crooked Bones. . . ."

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Maine Medical Journal

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Vol. XXIX *Portland, Maine, December, 1938* *No. 12*

Ragweed-Pollen Survey in Maine for 1937[*]

By Charles B. Sylvester, M. D.,[†] and O. C. Durham[‡]

Portland, Maine, and North Chicago, Illinois

Our chief motive in making a survey of atmospheric pollen in Maine was to promote a campaign for intelligent eradication of the weeds, but the data will doubtless prove of value to physicians engaged in preventive treatment and to victims of ragweed hay fever who wish to find a favorable refuge. We hope that this report will be the means of a wider appreciation of the buoyancy of ragweed pollen, which often rides at heights of several thousand feet and is carried for hundreds of miles. In Maine, as well as in other states, there have been spasmodic efforts by towns, counties and districts to destroy ragweed. These righteous endeavors would have been more effective if the magnitude of the problem had been better understood and if there had been co-ordination of effort on a larger scale.

The geography of Maine must be noted in order to see that the state is remarkably isolated by seashore and forested mountains where no ragweed can originate. The boundaries of the state are largely protective, and it is apparent that no state in the ragweed area east of the Rocky Mountains and north of Florida could so easily maintain a quarantine against ragweed pollen.

Not only does Maine have its very long ocean shore to the south and east, but it has to the west the White Mountains, continued in a long mountainous range across the northwest of the state. The extensive forest areas of Maine are also situated in the west, northwest, north and in the eastern margin of the state. The vulnerable border is evidently the southwest, between the coast and the White Mountains. On the northeast, New Brunswick is adjacent, sparsely settled, with few lines of communication, and usually with westerly winds. Also it may be that there is more frugal farming, with fewer neglected, uncultivated fields. Whatever reason is assigned, our survey evidences little dissemination of pollen across the Canadian border.

It is interesting to note that ragweed appears to have been introduced along the more frequented lines of travel. A theory has been advanced that railway cars and automobile tops with their ridged edges were carriers of pollen from distant states. The more likely explanation is that the increasing number of small farms, gardens and roadside ditches furnish ideal culture beds for ragweed and are thus a local source of air contamination. These, with the pollen brought in by prevailing westerly winds, account for our finding of a relatively high incidence of pollen in the southwestern part of the state.

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[*] Reprinted from *The New England Journal of Medicine*, September 22, 1938.

[†] Consultant in allergy, Maine General Hospital, Portland.

[‡] Chief botanist, Abbott Laboratories, North Chicago.

In his nation-wide atmospheric pollen studies one of us (O. C. D.[1]) exposed pollen slides during 1934 and 1935 at Bar Harbor and at Upper Dam on the Rangeley Lakes, also in 1935 at Eastport. One of us (C. B. S.) exposed slides in Portland during August and September, 1936, but we afterward decided that the shelter which had been used was not suitable, so a plan was arranged for a coöperative study in 1937. Dr. George H. Coombs, director of the Maine Bureau of Health, was immediately concerned in the success of such an air survey, and wished to make it state-wide in extent. The bureau furnished the expense of necessary material, and the labor in placing and collecting slides. The selection of receiving stations was made with the purpose of securing data from differing representative areas, such as the coast with its islands and headland resorts, the central and northern farming section, the cities and the extensive forests. However, it was obvious that we should make tests only where people are present in reasonable numbers in August and September.

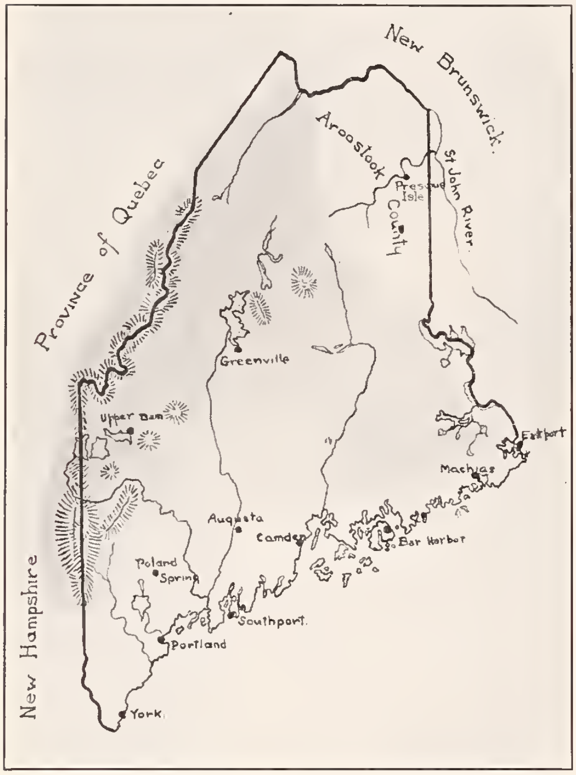

Figure 1. *Map of Maine, showing the mountainous boundaries and heavily forested areas.*

Ragweed counts having been published for Rangeley Lakes, Eastport and Bar Harbor, these important points were not again included. The regions first checked on the map of Maine were Aroostook County, Moosehead Lake, the deeply indented coast to the east of the Kennebec outlet, the Penobscot Bay shores and the more heavily populated southwestern corner of the state. The stations finally placed were those at Presque Isle, Greenville, Poland Spring, Augusta, Machias, Camden, Southport, Portland and York. Camden is omitted from our tabulations as it did not qualify for the entire season; its exposed slides showed a low count consistent with that of the other shore towns.

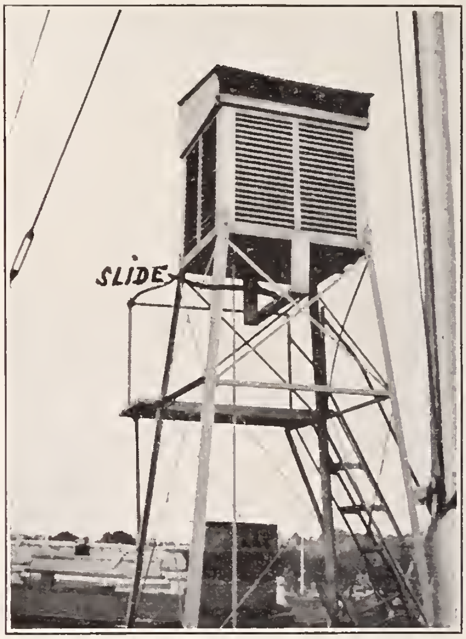

Figure 2. *United States Weather Bureau instrument shelter at Portland. The block holding the slide rests on the bar under the shelter.*

From previous clinical observations we expected the season to begin August 10. However, to check up our accuracy, we made our exposure August 8, and daily thereafter for fifty days. Results showed August 10 to be early enough for the first exposure. Uniform directions were given with each box of slides for the proper handling without contamination. The slides were coated with a thin film of white vaseline and labeled with the station and consecutive dates. They were exposed in a horizontal position, held in an ordinary clothes-pin clip fastened to a base. Protection from rains was afforded by a roof only. Slides were changed each morning. We took the precaution, as a proof of technic and identity, to have each pollen-receiver photographed, close up and distant, showing the elevation and freedom from lateral contamination and air deflection. The custody and care of the slides were placed in the hands of authorized observers at weather bureaus, fire stations, a state sanatorium, a state normal school, a C.C.C. camp, the state capitol and two resort hotels.

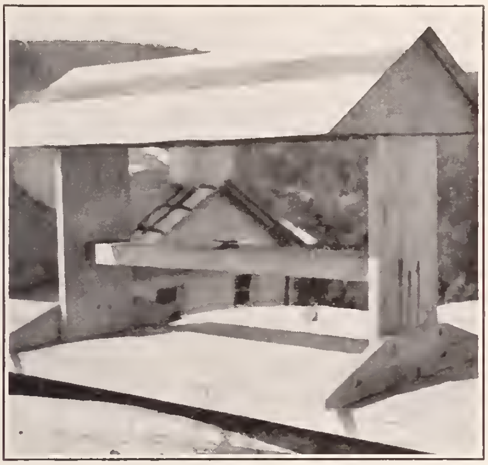

Figure 3. *Shelter used for the pollen slides exposed on the State House at Augusta.*

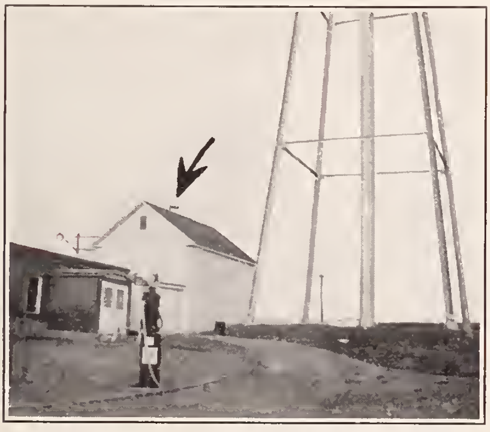

Figure 4. *Pollen survey station at Northern Maine Sanatorium, Presque Isle, Aroostook County. Note shelter on top of building.*

Counting was done by a standard method used by Durham[2] in his nation-wide studies: contiguous microscope fields in five separated paths across the width of the slide, approximately an area of 1.8 sq. cm. All slides were counted by our technicians in Portland and rechecked by one of us (O. C. D.).

Contamination of the air with pollen depends on two main factors: pollen production and pollen distribution. For abundant production there must be a reasonably large acreage of either waste land or farm land devoted to cereals. The character of the soil, the amount of rainfall and the average temperature also have much to do with the maturation of the pollen crop. Distribution of the matured pollen depends mostly on wind currents. Convection currents are mostly responsible for lifting the pollens to the higher altitudes and lateral currents for long-distance transportation. Thus while a given locality may be entirely free from local growths of ragweed because of unfavorable soil, or occupancy of the land by grass, forests or buildings, the air may be periodically or continuously contaminated by pollen brought in by the wind. The air of a large city is polluted, even in the business and best residential sections, by pollen produced in vacant lots, in the subdivisions and on adjacent farm lands. An undisturbed forested area within fifty miles of an agricultural area will experience periodic showers of ragweed pollen during the ragweed season when strong winds blow directly from the agricultural to the forested area. The small town or city which does not have subdivisions gets its pollen from surrounding agricultural lands or in some cases from distant weedy areas.

Much of the essential data obtained in the 1937 survey will be found in Table 1, in which are included for purposes of comparison average figures for New York City and Boston, as well as counts made in 1934 and 1935 at Bar Harbor, Eastport and Upper Dam. Hay-fever symptoms may be experienced when the pollen count is less than 25, but 25 has been chosen as a minimum figure for counting the number of hay-fever days in a given locality. For purposes of comparison any reasonable figure would do. The total count is obtained by adding the figures for each day through the season. The "ragweed

Table 1. *Ragweed Pollen Counts in Different Localities.*

City	*Population*	*Number of Hay-Fever Days*	*Highest Count for One Day*	*Total Ragweed Count*	*Ragweed Index*
Portland	70,810	18	114	1,225	25
York	2,532	5	78	348	8
Southport	412	5	65	369	8
Poland Spring	580	11	75	788	16
Augusta	17,198	6	57	573	9
Machias	1,853	2	39	250	4
Greenville	1,614	3	46	223	4
Presque Isle	6,965	0	14	84	1
Bar Harbor	4,486	5	76	426	8
Eastport	3,466	4	43	280	6
Upper Dam (Rangeley Lakes)	78	1	69	139	2
New York City	6,930,000	27	337	1,675	39
Boston	781,000	10	140	790	15

index" is figured on the same basis as was used in a previous nation-wide evaluation of hay-fever-resort areas. On this arbitrary scale, some mid-western cities have index figures of 100 or more. Examples follow: Buffalo 100, Indianapolis 124, Toledo 96, Chicago 74. The figure is obtained by assigning one point for each day when the count reaches or exceeds 25, one point for each 100 grains of pollen on the day of the highest count and one point for each 200 grains of pollen in the seasonal total.

The focus of local atmospheric ragweed-pollen contamination in Maine would seem to be in the agricultural area of the southwestern part of the state. Portland is really the only point studied where the ragweed problem approaches in severity that of the large cities of the central and eastern states. In Portland a considerable part of the pollen is probably from vacant lots and untenanted subdivisions, although ragweeds will be found along public roads and in gardens at some distances into the more rugged portions of the state.

An annual total fall of less than 500 ragweed-pollen grains may be considered a very good record, but there is no guaranty that favorable conditions will continue without active measures for control of ragweed. Many localities, which were once entirely free from atmospheric contamination, have become badly contaminated in the course of a few years because of utter neglect of adjacent gardens and fields. In the agricultural section of the central states ragweed control is a practical impossibility, but in a district where the acreage of tilled land is small, or the land kept free of weeds, coöperative endeavor could result in decided reduction of the pollen content of the air.

A noticeable feature of the behavior of the 1937 ragweed season in Maine is the three periods of atmospheric contamination (Fig. 5). The first occurred about August 20, with almost a maximum count in Portland, York and Southport. The second and heaviest period of high concentration occurred during the first week of September, with maximum counts at all stations. A minor flare-up occurring on September 15 was particularly evident at Portland, Augusta and Poland Spring, but was felt at all stations. It seems quite evident that these three showers were state-wide. The wind velocity at the various stations at the time of these three showers was not particularly high, but a careful study of the records shows that the prevailing wind direction throughout the state on August 20 was west, and on September 2 and 15 south or southwest. It would seem, then, that the pollen showers can be accounted for on the basis of wind direction rather than wind velocity.

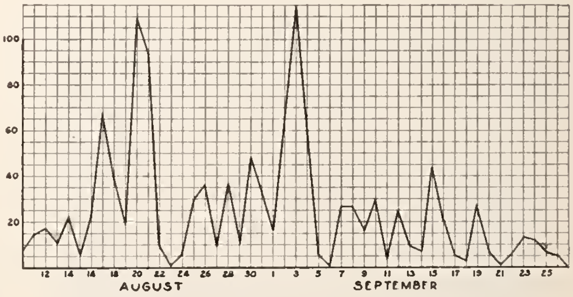

Figure 5. *Ragweed pollen season of 1937 at Portland. The three periods of state-wide atmospheric contamination are clearly shown in this record. The scale refers to the number of ragweed pollen grains found on an area approximately 1.8 sq. cm. on each slide.*

The time of maximum pollen production in Maine coincides very well with that in adjacent eastern states. The climax on September 2 coincides with the date of highest ragweed pollen incidence in 1937 in New York City. As an example of the abundant evidence in this study of pollen transport, we may cite the following facts: The slides were exposed in Poland Spring on a tower 120 ft. high. There is little local growth of ragweed, yet on September 2, 3 and 4 and again on September 15, the count at Poland Spring varied from 54 to 75. Between these two waves the concentration at Poland Spring dropped to 5 and 6 and in one instance to 0.

The surprise of our survey lies in this: the cities have more atmospheric ragweed pollen than has the country. Within a dozen miles of Maine's largest city can be seen acres of neglected fields with a bountiful crop of ragweed and little else, while in the rich agricultural Aroostook County, tillage land is too valuable to neglect. Our survey shows that Aroostook County has the lowest ragweed count in the state. Most soils, if not made to produce crops, will produce ragweed. It is evident that soils, like human beings, should be kept busy.

There is an astonishing ignorance, even in the medical profession, of the identity of the growing ragweed. It is so common and homely and generally dust-covered that it is unrecognized. Attention should be called to the under surface of the blossoms of the maturing plant, with its thousands of tiny yellow anthers bursting with pollen. The enormous pollen-producing power of the ragweed should be understood. Photographs have been published of the ragweed-lined sidewalks of Cleveland, Ohio, which has an atmospheric load measured in tons of pollen. The back yard and the roadside and edges of sidewalks are commonly beds of ragweed. The public must learn to appreciate the unseen atmospheric load of pollen and the ubiquitous ragweed. The seeds remain viable for many years, ready to spring up in every break in the soil. Vacant lots, back yards, gardens, roadsides and neglected fields offer a thousand opportunities.

Maine places "Vacationland" on its automobile plates, and the state is filled with summer camps for boys and girls. It should protect its reputation as a health resort. It has every natural advantage. Many seek freedom from hay fever, and many claim to find it at mountain and shore resorts. On strict analysis, this freedom is found to be actually relative, with some clinical manifestation, even if so temporary or slight as to be happily forgotten. The public should learn that not "climate" but pollen pollution of the air causes hay fever. We cannot repeat too often that ragweed has only a nuisance value. It is always a pest, can be nothing but a pest, and is in this state the sole cause of late summer and fall hay fever.

The survey and report of a public-health nuisance should be followed by rational suggestions for its eradication. Ragweed is an annual, and therefore its roots do not require removal. Along the roadsides and in fields it can easily be cut, and must be burned or otherwise destroyed to prevent maturing of the pollen. Local destruction of ragweed, however thorough, must have adjacent coöperation, which in Maine should extend to the whole state.

We have shown the necessity for some knowledge of geography to explain the prevalence and distribution of ragweed, some knowledge of agriculture and soils, some knowledge of botany, some understanding of wind currents. There is left the understanding of human nature, and the cultivation of its intelligence to secure a concerted campaign in eradication. The enthusiasm of health resorts or towns and the zeal of local service clubs may be commended as examples of public spirit, but must be well advised to secure coöperation in factual result.

Air pollution by ragweed pollen is a menace to public health. Should not its destruction become a proper function of the state health bureau? Would not each householder or tenant destroy his own weeds rather than have the health board direct public attention to the nuisance? Destruction is advised prior to August 1. If neglected, should not health officers be empowered as with other health nuisances to destroy such pests at the expense of the owner? A sentiment can be built up which would make the public ragweed-conscious, and which would discredit neglect in its destruction.

SUMMARY

Owing to the geographical position of the state, with its more or less protective boundaries against ragweed, Maine should be a good proving-ground for a concerted campaign of eradication. A pollen survey was first necessary. Beginning August 8, 1937, slides were exposed for each of fifty days at nine authorized receiving stations in cities, farming towns, mountains and seashore, and were carefully counted. Maps, graphs, and tabulations accompany the text. Air currents as distributing agents were studied. Weather bureaus and forest wardens contributed to the success of the survey in furnishing data of storms, wind directions and velocities. A low ragweed count was found in nearly the whole state, a negligible amount in agricultural Aroostook County; the highest count, comparable with that of neighboring states, was in the southwest corner, which does not have any mountain-forest barrier.

Ragweed pollinosis is rated as an air-pollution problem for boards of health. An appeal is made for intelligent state-wide coöperation in eradication.

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FOOTNOTE. For fourteen years uniform studies of the pollen content of the air have been made by O. C. Durham of Abbott Laboratories in collaboration with the United States Weather Bureau. The error of the old notion about frost marking the end of the ragweed hayfever season is shown this year in the Great Lakes area by the abrupt termination of ragweed pollination ten days earlier than usual, when there were excessive rains and cool weather in September before any frost occurred. Excellent development of vegetation during June and July in the north central states promised the most severe ragweed hayfever year on record, but adverse weather conditions during the time of pollination held the aerial distribution of pollen in the north central and Great Lakes area to about the average amount. On the eastern seaboard the season was the heaviest on record. At Boston, Philadelphia, and Washington, the total exceeded that of any previous year, with the greatest increase, about 50%, at Boston.

For the season of 1938 in Maine, slides were exposed for the fifty-day season at Houlton, Rockland, Rangeley, Poland Spring, and Speckle Mountain in Grafton. The greater abundance of growing ragweed was marked in Maine, as noted by Durham on the whole Atlantic seaboard. A complete report of pollen distribution, including comment on hurricane effect, will be made later.

C. B. S.

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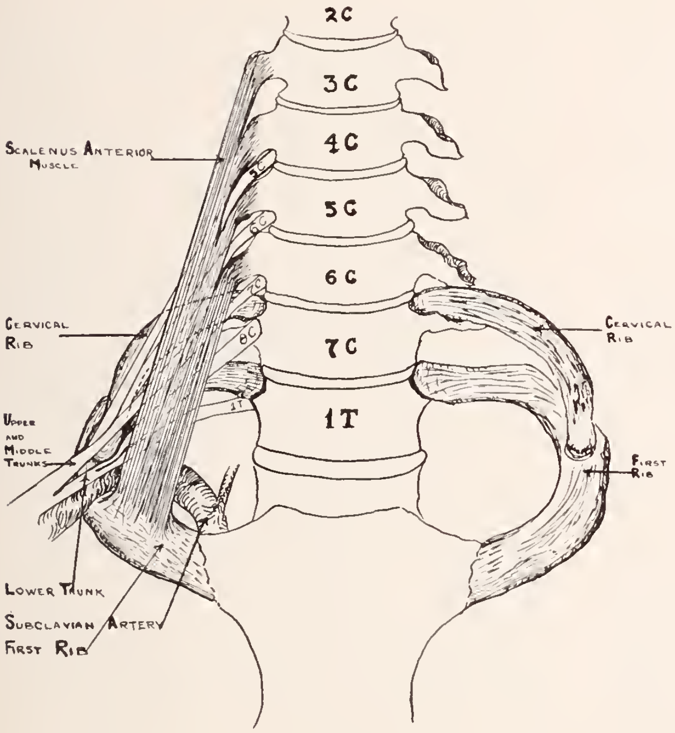
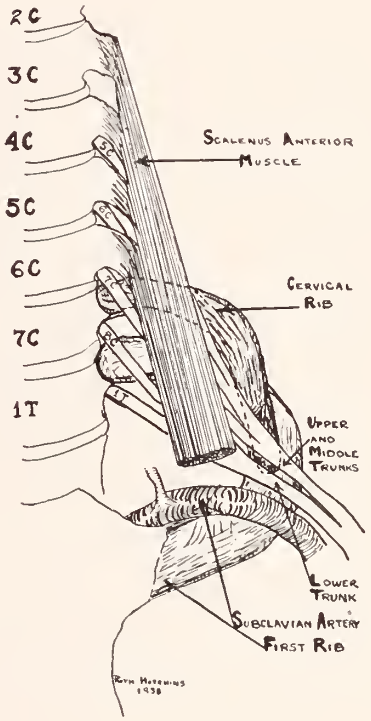
Developmental Abnormalities Simulating Arthritis of the Shoulder

REPORT OF A CASE

By Allan J. Stinchfield, M. D., Skowhegan, Maine

A cervical rib or an abnormal position of the scalenus anterior muscle may cause a syndrome consisting of pain in the shoulder above the clavicle or along the medial aspect of the forearm; nerve disfunction in the arm, such as, paraesthesia, hyperaesthesia and anaesthesia with atrophy of the small muscles of the hand which are supplied by the ulnar and median nerves. The pain is aggravated by rotation of the head toward the affected side. In more severe cases, pressure on the subclavian artery causes diminution of pulse, numbness, coldness and formication. Turning the head toward the affected side or elevation of the chest may cause further circulatory disturbances resulting in obliteration of the pulse.





Historically, we find that the founders of the science of anatomy, Galen and Vesalius, described cervical ribs. In 1860, Wilshire described symptoms produced by pressure of a cervical rib on the brachial plexus and subclavian artery. The embryonic formation of these supernumerary ribs is attributed by Jones to a conflict between forming plexuses and ribs. Due to the fact that the vertebral column grows faster than the body, the nerves which supply the extremities leave the cord at an oblique angle as is shown by all the major plexuses.

The illustration shows the relation between the cervical rib, the brachial plexus and the scalenus anterior muscle. Extension or tension on the scalenus anterior muscle causes pressure to be applied to the subclavian artery and brachial plexus which cannot be displaced posteriorly because of the unyielding cervical rib. The incidence of cervical ribs as shown by Adson and Coffey[1] at the Mayo Clinic was 0.056% or 303 cases in 540,413 patients. Other estimates of the incidence of cervical ribs vary between 0.03

and 0.1%. More frequent roentgenological study by the general practitioner would probably reveal that the incidence of the cervical rib is considerably higher than even the highest figures quoted. They are bilateral in 67% to 80% of cases. In Adson and Coffey's series the ribs were somewhat more common on the left than on the right but were more frequent bilaterally. Fifty-five per cent of the cervical ribs were discovered accidentally. They were symptomless. In one-third of the cases, the symptoms were mild as in the case to be reported. Diagnosis rests mainly with the roentgenologist and may present some difficulty as the ribs may be small and not easily recognized. The treatment in mild cases consists of rest for the arm with heat locally and an adequate diet containing large quantities of the antineuritic Vitamin B. Foci of infection should be eliminated in order that the injured nerve should not be adversely effected by toxins. In the more severe cases, tenotomy of the scalenus anterior muscle at its insertion on the first rib will give prompt relief. It is now believed that the technique of Adson and Coffey, which is that of sectioning the scalenus anterior muscle, is preferable to the older method of removing the rib.

This same syndrome has been reported when there were no cervical ribs present. Ochsner, Gage and DeBakey[2] observed six cases with the typical symptoms of compression of the plexus and the artery in the absence of the cervical rib; all in females. Ochsner observes that this syndrome is a definite entity which is identical with that of the cervical rib. The compression may be due to the abnormally low position of the shoulder, to the high fixation of the sternum and ribs, to the low origin of the brachial plexus and to the elevation of the first thoracic rib due to the spasm of the scalenus anterior muscle. Four of their cases were operated on by resection of the lower portion of the scalenus anterior muscle with complete relief. Carrol[3] reported complete relief was obtained in one case by the same method.

Case Report

Mrs. X, age sixty, complained of "arthritis" in left shoulder and arm for two months' duration. It consisted of a continuous dull ache which extended along the upper border of the left trapezius muscle to the point of the shoulder, over the deltoid muscle with a smarting sensation at its insertion. Tenderness was present at the insertion of the deltoid. Work tended to increase discomfort. A sudden weight on the left arm aggravated the pain and at times seemed to paralyze it. Some days she was bothered all the time and on others not at all. Local application of heat relieved the pain. The only paraesthesias noted were the burning, prickling, and soreness at the insertion of the deltoid. Patient complained of occasional joint pains in other parts of the body. An abscessed tooth was removed three weeks before the patient came to my office. The diet of the patient seemed adequate.

Previous illnesses included most of the common diseases, arthritis of the fingers and several abdominal operations. Venereal disease was denied.

Examination locally revealed skin temperature to be normal, no gross atrophy of muscles of arm or hand and moderate tenderness at insertion of the left deltoid muscle. The biceps jerk, the triceps jerk and knee jerk were equal and active. No Babinski or Hoffman. Grossly there was no muscle weakness. Neither was there any loss of sensation to pain or temperature. The pulse in the two wrists were equal and not changed by moving the head. The blood pressure in the two arms was equal and unaffected by position of the head. Kahn and Hinton tests were negative. The blood count was within normal range. The urine was also normal. X-rays of the cervical region were taken and revealed bilateral ribs extending for three centimeters from the upper border of the seventh cervical vertebra. The left shoulder joint was entirely free of any arthritic changes. The fact that, in this patient, the cervical ribs are short accounts for paraesthesias and pain only along the course of the upper nerves in the brachial plexus, namely, the fifth and sixth cervical nerves. It also accounts for the fact that there were no circulatory disturbances.

Treatment in this case resolved itself into putting the arm at rest, applying heat and mild counter-irritants, mild massage and diet supplemented by Vitamin B. (One yeast cake a day for eight weeks.) Clinical improvement was noted and continued until the patient resumed heavy work.

SUMMARY

1. The scalenus anterior muscle either with or without an anomalous cervical rib may cause pressure symptoms on the brachial plexus and the subclavian artery.

2. Tenotomy of the scalenus anterior muscle will relieve the symptoms if medical treatment is not adequate.

3. A case with small cervical ribs exhibiting pressure symptoms on the brachial plexus is presented.

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*Hospital Atmosphere**

By PEARL R. FISHER, R. N., Superintendent, Thayer Hospital, Waterville, Maine

By hospital atmosphere we do not mean the prevailing degree of heat or cold emanating from the heating plant (nor the humidity these August days)—nor the odors of ether and iodoform so noticeable to the uninitiated. But rather—that pervading influence, that nebulous something, which surrounds the patient from the time he enters the hospital until his discharge. This may be favorable or not, depending largely upon the hospital's idea of service, and how it is put into practice.

On admission the patient receives his first impressions. Like most first impressions, they are likely to be lasting, or at least will influence the mental reaction of the patient during his stay, and probably even after discharge. The average patient would naturally rather be well than sick, and he usually enters the hospital against his wishes, and perhaps sometimes against his judgment. Oftentimes it is a new and a terrifying experience for him. An atmosphere of thoughtful and personal interest manifested by the hospital personnel does a great deal in overcoming any feeling of apprehension on his part. It will be much easier for him if he is made to immediately feel that he is a welcome and desired guest. Hospitals might do well to imitate hotels in this respect. This attitude of friendliness and sympathy should not be centered in merely one department, but must be felt at the front door, in the office, over the telephone, and carry through the nursing service and the entire personnel who come in contact with the patient. (And may I interject the thought right here—of the real value of a good telephone voice in answering inquiries regarding patients.) Definite information, given in a personal manner, regarding hospital regulations and service should be made an unfailing part of the admission routine. This work should not be delegated to an untrained subordinate. It calls for experience, tact, courtesy, and an understanding of human nature. Bulletins or information cards, while of unquestioned value, are hardly sufficient. A patient will relax to hospital routine more easily if the dozen or so perplexing questions in his mind can be answered. For instance—if he understands what the visiting hours are, that his relatives can remain the day of the operation, that he may have a telephone in his room, that his paper will be brought to him daily, and that it will be possible for him to have a barber if desired. Nurses and doctors to whom hospital routine is so commonplace sometimes forget that this is a strange experience to a person who has never been in a hospital. The average person can meet difficult situations more adequately if he understands them beforehand. A few words of encouragement to a new and bewildered patient and, perhaps what is equally important, to his anxious relatives, will go far in dispelling the natural dread of a hospital.

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* Read before the 1938 Annual Meeting of the Maine Hospital Association held at Lakewood, August 31, 1938.

The rigidity of hospital routine has been frequently criticised. Undoubtedly there is some foundation for this criticism. Even that eminent surgeon, Dr. Harvey Cushing, found certain phases of hospital life disturbing, when he, for the first time, had occasion to experience the routine as a patient. Undoubtedly you recall his article in which he stated that he found that food carts and surgical carriages made unnecessary noises going down the corridor—that being awakened at an unearthly hour to have his face washed, when he had absolutely nothing to do all day, was a decided bore, to say the least. But it was the last straw when they took his trousers out of his room. He was completely defenseless. And when we think of it—wasn't he right? And aren't these needless annoyances? Many noises could be easily eliminated with a little attention to equipment and better arrangement of schedules. It should not be necessary to awaken a patient at an early hour—when sleep would be more beneficial than having his face washed or an early A. M. temperature taken. And why could not patients' treasured personal effects be left with them?

An efficient, sympathetic and friendly nursing staff is of tremendous importance in helping the patient adjust himself to his new surroundings. There are times when this adjustment is no small task, and frequently calls for tact, diplomacy and patience that is monumental. In her attitude toward the patient, the nurse must bear in mind that in her work she is dealing with people who are physically and mentally ill. She must recognize the fact that the sick person is less able to cope with annoying situations and is apt to have strong personal preferences which may be hard to understand. But the ability to understand should be one of the fundamental qualities of a good nurse. Thoughtfulness in explaining to the patient and helping him to understand his various treatments, examination, diets, and tests will do a great deal toward making his hospital stay a pleasant one.

Probably nowhere is a friendly, yet orderly atmosphere more necessary than in the operating room. So often the patient is brought into a room which presents a picture of confusion. There may be unavoidable delay, scurrying about of attendants, clatter of instruments, and he lies there wondering what is about to happen. This naturally increases his tension. Most of this confusion could be avoided if we only kept in mind its possible effect upon the psychology of the patient; and the value, on the other hand, of a quiet, orderly operating room atmosphere. Probably at no other time or place is an understanding word or gesture more appreciated than in the operating room, just prior to the administration of an anesthetic. It is a great consolation to the patient to have a few friendly words spoken, perhaps a hand held, as the anesthetist prepares to carry on.

If ever a patient is thoroughly sick and miserable, it is during the immediate period of postoperative reaction. Here is where thoughtful and attentive ministrations on the part of the nursing service will be thoroughly appreciated and remembered. Oftentimes in the busy routine of a hospital morning, it may be difficult to give recovery patients all the desired care, but it would seem worth while, at least, to try just a little harder in this respect.

The detail of giving preoperative and postoperative care is an old story and needs no repetition here. But it might be well to suggest from a humane standpoint the value of alloying the patient's fear of dressings, or the removal of stitches, or other unpleasant but necessary features of the postoperative period.

There is so much that can be done during the period of convalescence, "when time hangs heavy." During this period the patient has an opportunity to really analyze his hospital service. At the same time his mind can quite easily become occupied with all sorts of imaginary ailments. An alert, interested nurse can do a great deal in preventing a patient from becoming too introspective, especially if she is able to converse intelligently on any number of subjects, such as books, travel, pictures, or even better still, upon any hobbies discovered in the patient. She can see that he has interesting books and magazines to read. Too often the selection of reading matter shows woeful lack of thoughtfulness. One cannot expect a husky convalescent male to become interested in the Louisa Alcott stories, or at the same time a nice, conservative old lady in *Esquire*.

Unfortunately, most hospitals do not place enough emphasis on the care of the convalescents, naturally the emphasis being on the acutely ill. But with a little thought and effort, surroundings can be made pleasant, rooms can be kept clean, flowers attractively arranged and trays made inviting.

It is good psychology, and great aid in the patient's recovery, to keep him in a happy frame of mind and pleased with his surroundings. This likewise holds true of his relatives and friends. An apprehensive relative may be put at ease by a few words of friendly reassurance regarding the patient. Sometimes the offer of a cup of tea, or a tray at lunch time is a kindly and appreciated gesture. This friendly, solicitous interest on the part of the hospital is bound to create a favorable reaction in the mind of the patient and his family. It is the seemingly small, thoughtful courtesies that often will be remembered long after the more significant details of his hospital experience have grown hazy.

The aim of the hospital should be to surround the patient with an atmosphere of friendliness and sympathy and to assure him that the hospital is interested in him as an individual and that its main purpose is to give him the best possible care. To achieve this atmosphere requires the interest and cooperation of the entire hospital organization. This can be brought about only by proper and careful selection of the personnel. Character, ability, loyalty, background and a good disposition are some of the most desirable qualities. A personnel with these qualities soon develops an *esprit de corps* which is extremely worth while and makes for a hospital organization which is congenial and efficient. And this desired atmosphere then becomes more of a reality.

The complexity of hospital life demands rules and regulations, but it might be well to temper rigidity with flexibility, to interpret rules with liberality and intelligence, and to qualify efficiency with human sympathy and understanding.

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The President's Page

To the Members of the Maine Medical Association:

During the past week I have received several written comments on my last President's Page in which I referred to the advisability of more young men beginning the practice of medicine in the rural districts of the State of Maine. Some of these comments were favorable while others were in the nature of criticism, all of which has led me to believe that this subject warrants further discussion.

One writer referred to the unfortunate experience of shoveling his car out of deep snowdrifts and travelling on skiis during the winter months and in payment for his services received vegetables which later proved to be a "frozen asset."

This happened in a small town in the northern part of Maine, and after eight months of this practice he finally sought a haven of refuge in the mid-west fully convinced that it was impossible to earn a living in the rural districts of Maine.

This young man apparently is sincere in his remarks and asks for the solution of this problem, expressing the hope that steps will be taken in the near future to insure a living income for a young medical graduate who really would like to take up a country practice in Maine.

In reply to several similar inquiries I can only say that a considerable part of my early practice was devoted to serving the country people and over a period of twenty-nine years I have had many such experiences as have been related above. I had no automobile, therefore it was the horse that I shoveled out; skiis were not in vogue so I finished my journey on snowshoes and many times there were no vegetables to spare and my only remuneration was a cup of Red Rose tea and Washington Pie for breakfast.

In spite of these seeming hardships some of my happiest hours have been spent among the country people, and furthermore I am convinced that if the young professional men of today are made of the same timber as that of their ancestors there will be little difficulty in solving this problem which confronts us today.

If all of the recent graduates aspire to become leaders among the "four-hundred" in a few of the larger centers and are unwilling to make their reputation in the rural districts, the government will most certainly take advantage of this fact and furnish what they consider adequate medical care for those localities and such care will be rendered under the direction of the politicians who are laboring under the disguise of humanitarians.

Willard H. Bunker, M. D.

Editorial

Medical and Hospital Service Insurance

Anyone who has given this important subject sufficient thought or study only too well appreciates the potential complexities in the whole situation. If health insurance be made compulsory, since the majority of patients would not voluntarily subscribe, a valid objection obtains since as pointed out in his presidential address before the New England Surgical Society by Dr. John M. Birnie this would make for triple compulsion. The individual is compelled to take it; he is compelled to take a designated doctor; and the doctor is compelled to render the service. Such compulsion would seem to be a most certain way to defeat several fundamental principles which assure to the public medical care of the highest type. The right of the physician to control the terms of his service; the free choice of the physician by the patient and the free choice of the hospital.

Just what constitutes true medical indigency remains more or less a question. It cannot be determined by the matter of income alone. There are some in the extremely low income groups who seemingly can and will meet obligations far beyond what a casual observer might believe possible. There are still in this country men and women whose cash income IS small but who have yet to become objects of public charity or graft. In the average community such people have little or no trouble in obtaining medical care. They are taken care of gladly and willingly at fees commensurate with their ability. Those of the public who cannot assume such obligations should, in all fairness, be assisted by their local community or State through tax-supported funds. This is a community problem to be aided in every possible way by the medical and allied professions. One medical witness, before the recent grand jury investigation of organized medicine, deprecated, it is reported, proposals to subsidize treatment in the hands of the general practitioner for people unable to afford regular medical charges. What he actually did propose is not stated but it would seem the alternate would be that they become wards of the Government, Federal or Local, subject to all the delightful possibilities that means.

All plans for medical and hospital expense insurance—sponsored commercially or through and by organized medicine—are designed for low and medium income class patients. The average indigent probably cannot afford the premiums; obviously those of means would not consider the indemnities sufficient. At the annual meeting of the American Hospital Association, recently held in Dallas, an optimistic tone pervaded the conclusions of the Board of Trustees which was submitted to and approved by the House of Delegates of that important organization. With a present enrollment of some 2,000,000 subscribers, with a membership increasing at the rate of a million a year, plans for hospital services now standing approved are not only materially aiding in the payment of hospital bills but the Association feels is contributing to the preservation of the private practice of medicine. The omission, however, of any provision for physicians' fees in hospital cases places non-profit hospital care insurance beyond the reach of many employed workers of limited incomes. Undoubtedly a strong demand exists, it will become even more noticeable, for the creation of hospital service plans embodying this feature and adopted to the needs and means of those of the low income group. The American Hospital Association feels if these plans are successful, and it would certainly seem that they can be made so, they will reclaim a segment of medical service even larger than is now protected in plans of operation.

The association is prepared to approve plans that meet with certain stipulations, these are embodied in the conclusions to the House of Delegates, and which can only meet with the approval of organized medicine. Medical care insurance must be approached slowly and carefully, with much thought and study, for its possibilities if handled correctly are of vast importance. Control of this service by commercial interests will not be for the best interests of the profession or the public it serves. Both the American Hospital Association and the American Medical Association believes that the establishment of cooperative plans for both services is certainly possible without invalidating any of the ideals or principles associated with medical care that are vital. Surely a service available and possible to a numerically large and important percentage of the people, which will enable it to meet its medical and hospital bills, cannot but appeal to a profession long overburdened with its disproportionate share of service for which it receives little or absolutely nothing. Plain common sense demands that we lend every effort, individually and collectively, to those delegated to further such a need for the benefits accruing the profession of such a service, properly planned and properly administered, are almost beyond calculation.

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County News and Notes

County Secretaries Endorse Educational Plan

The County Secretaries in session at the Central Maine General Hospital, Lewiston, on November 4, 1938, voted to endorse the proposal whereby the Committee on Graduate Education map out a program of Educational Meetings to be held for the County Societies. This program to be presented before the House of Delegates at the June, 1939, meeting and, if approved, to be effective in the Fall of 1939.

Androscoggin

The regular meeting of the Androscoggin County Medical Society was held at the Auburn Y. M. C. A., November 17, 1938, at 8.40 P. M.

Following the business session, Dr. R. V. N. Bliss of Blue Hill read a paper entitled "Hospitals and Laity Take up the Practice of Medicine in Ruritania." This was one of the most interesting and clear-cut presentations on the subject this society has had the pleasure of hearing and was appreciated by everyone concerned.

Adjourned at 10.40 P. M.

Respectfully submitted,

A. E. Peters, M. D., *Secretary.*

Cumberland

Jack Spencer, M. D., Roentgenologist, announces the opening of an office at 31 Deering Street, Portland, Maine, in association with Langdon T. Thaxter, M. D.

Doctor Spencer, formerly of Boston, has held the following appointments: Assistant Roentgenologist at the Collis P. Huntington Memorial Hospital, Research Fellow in Roentgenology at Harvard Medical School, Assistant Roentgenologist at the Massachusetts General Hospital, and Consultant in Radiology at the Palmer Memorial Hospital and the Boston Dispensary.

Robert B. Love, M. D., of Gorham, has recently been appointed a Cumberland County medical examiner by Governor Lewis O. Barrows.

Portland Medical Club

The regular monthly meeting was held at the Columbia Hotel, Tuesday evening, October 4th, at 8.15 P. M. Twenty-six members were present.

Resolutions on the death of Dr. Edville G. Abbott were adopted by the Club.

The paper of the evening was by Dr. Isaac Webber and his subject was *Some Further Observations on Goitre.* This instructive talk was illustrated by lantern slides.

Alice Whittier, *Secretary.*

The regular monthly meeting was held at the Columbia Hotel, Tuesday evening, November first, at 8.15 P. M. Twenty-eight members were present.

Dr. Gordon N. Johnson was elected to membership.

Resolutions on the death of Dr. Lester L. Powell were adopted by the Club.

Drs. H. H. Swift, Mortimer Warren and E. H. Drake were appointed as the nominating committee for officers for 1939.

An excellent paper on *The Management and Treatment of Lues* was delivered by Dr. Oscar Johnson.

Alice Whittier, *Secretary.*

Your Membership Expires December 31st

Kennebec

The November meeting of the Kennebec County Medical Association was held at the Elmwood Hotel in Waterville, Maine, November 17, 1938.

Clinical Session at 5.00 P. M. with the following program, over which Dr. Samuel H. Kagan, President, presided.

1. Mediastinal Tumor, M. Lubell, M. D.
2. Trichomas Vaginalis, C. E. Towne, M. D.
3. Atropine in Luetic Keratitis, Howard F. Hill, M. D.
4. Tonsilitis-Peritonsillar Abscess and Septecemia, L. A. Guite, M. D.
5. Congenital Dislocation of Hip, E. M. Tower, M. D.
6. Intestinal Obstruction, J. G. Towne, M. D.
7. Foreign Body Tumor Cæcum, E. H. Risley, M. D.
8. Lobar Pneumonia-Empyema, John O. Piper, M. D.
9. Perforated Gastric Ulcer, N. Bisson, M. D.
10. Lateral Sinus Thrombosis, F. T. Hill, M. D.

Dinner was served at 6.30 P. M., followed by a business meeting.

W. H. Bunker, M. D., of Calais, President of the Maine Medical Association, was present and spoke of the doings of the State Association and the service the profession is giving the people in Maine.

At the scientific session, Dr. H. Edward MacMahon, Professor of Pathology at Tufts College Medical School, Boston, before presenting his lecture on Bright's Disease, had a question period to bring up matters pertaining to clinical pathology for clarification. To the question as to the value of a frozen section, the doctor replied that he did a frozen section only on breast tumors. He felt that frozen section of uterine scrapings were not safe for diagnosis. Replying to the question, "What about chronic appendicitis?", Dr. MacMahon stated that he believed that there is a definite condition of an active chronic inflammation, one that is not burned out. A healed, scarred appendix is not chronic inflammation. There may be repeated acute attacks in a healed, scarred appendix, and this is not chronic inflammation. Taking up the matter of kidney conditions, Dr. MacMahon brought up the fact that the kidneys became important after birth, not in intrauterine life. He mentioned two cases of infants with no kidneys. Dr. MacMahon believes that the classification of kidney diseases should be based on pathological histology, chemistry and clinical cooperated studies. He divided them into three classes:

1. Inflammatory lesions involving all the glomeruli—causing "diffuse glomerular nephritis." Focal embolic areas found in the kidneys in cases of infectious endocarditis do not belong in this classification.
2. Degenerative lesions involving the glomeruli.
3. Diseases involving the blood vessels of the kidneys.

Dr. MacMahon's deep interest in this subject, resulting from the years of special research and study made the lecture all the more interesting and vital to those present. This was another valuable contribution to the post-graduate program that the association has been privileged to hear this year, and which is resulting in improved service to the community.

There were 40 members and guests present.

Respectfully submitted,

Frederick R. Carter, M. D., *Secretary.*

Penobscot

F. D. Weymouth, M. D., of Brewer, was elected President of the Penobscot County Medical Association at the annual business meeting and election of officers at the Bangor House, November 15th.

Other officers chosen were: Allan Woodcock, M. D., Bangor, Vice-President; Forrest B. Ames, M. D., Bangor, Secretary-Treasurer; L. J. Wright, M. D., Bangor, Delegate to the Maine Medical Association 1939 Annual Session, and Asa Adams, M. D., Orono, member of the Board of Censors.

The election preceded the annual banquet at which Frederick T. Lord, M. D., of the Massachusetts General Hospital, Boston, was guest speaker. Dr. Lord spoke on *Pneumococcus Pneumonia*, and illustrated his talk with silent and sound movies. He also made the medical rounds with members of the Association at the Eastern Maine General Hospital Tuesday morning at 9 o'clock, and conducted a clinic and discussion of cases at the Hospital in the afternoon.

There were 61 present.

Forrest B. Ames, M. D., *Secretary.*

Piscataquis

A meeting of the Piscataquis County Medical Association was held at Dr. Bundy's residence in Milo on November 17th. Nine members and three guests were present.

The application of Burton Sanford Marsh of Greenville Junction was read and he was elected to membership.

N. H. Crosby, M. D., of Milo, related some of his experiences in the practice of medicine in earlier years.

Henry Knowlton, M. D., of Bangor, spoke on Basic Facts in the Treatment of Diabetes.

It was a very enjoyable meeting.

Respectfully submitted,

N. H. Nickerson, *Secretary.*

Sagadahoc

The regular meeting of the Sagadahoc County Medical Society for October was held at the Hotel Sedgwick on Wednesday, October 19, 1938, at 6.30 p. m.

President Pratt of Richmond, presiding.

Members present were Drs. Pratt, Jacob Smith, Stott, Fuller, Winchenbach and Kershner.

Guests were State President Bunker of Calais, Councilor Ellingwood of Rockland, Webb of Brunswick and Owen of Bath.

Minutes of the last meeting read and approved.

Applications for membership of Edwin M. Fuller and Albert Owen of Bath were read and approved by the councilors and unanimously accepted by the Society.

Survey reports of A. M. A. were distributed.

The question of advisability of attending physicians' names appearing in newspapers was discussed and it was decided that the matter could be handled without any formal action by the Society.

State President Bunker spoke on:

1. Graduate Medical education in Maine, and the use of our own specialists and leaders for teaching.
2. The current attempts to socialize medicine.
3. State association's attitude toward Osteopathy.
4. County Secretaries, their value and failings.
5. Malpractice.

Councilor Ellingwood, recently returned from the house of delegates meeting in Chicago, told of the points of discussion taken, concerning:

1. Adequate Medical Care.
2. Stand taken by Osteopathic convention.
3. Stand taken by National Medical Society (negro).
4. Propaganda of Government agencies for regimentation of Medicine.
5. Segregating patients according to income.
6. Move being made to keep politics out of medicine.
7. Status of A. M. A. as to being a trade or educational organization.

Following the meeting Mr. Prescott of the Winthrop Chemical Co. presented a moving picture which showed some of the causes of sterility, male and female, and gave some interesting points on diagnosis and treatment.

Meeting adjourned at 10.30 p. m.

The next meeting will be on November 22nd, at the Hotel Sedgwick, Bath, Me., at 6.30 p. m. Dinner and program.

Respectfully submitted,
Francis A. Winchenbach,
Secretary.

Somerset

The regular fall meeting of the Somerset County Medical Society was held at "Concord Haven", the home of Mrs. L. J. Williams, in Solon, on October 18, 1938.

The meeting was called to order by President Walters of Fairfield at 5.00 P. M. and after the reading of the record of the previous meeting the secretary read a letter from State Secretary Carter relative to the Study of Medical Care, requesting that the members get their papers filled and sent in as soon as possible for October.

The speaker for this occasion was Dr. Cromwell, Superintendent of the Central Maine Sanitorium at Fairfield, who gave a very interesting talk on the former conception and treatment of tuberculosis as compared with the modern treatment of this disease, and gave evidence of what was being done along this line by showing X-Ray plates of the chest demonstrating cases before and after treatment. He also urged that doctors and nurses should be diligent in their search for incipient cases.

He maintained that if cases of tuberculosis could be handled as other contagious cases, that the disease itself would in time be rare.

While the meeting was in session the ladies of the party were enjoying contract bridge.

After the meeting and program were completed, and the meeting adjourned, an excellent dinner was served under the management of Dr. and Mrs. Ball of Bingham.

We are indebted to Mrs. Williams who so kindly opened her beautiful home to us for this occasion, as this location and homey atmosphere enhanced the enjoyment of all those present.

Maurice E. Lord, *Secretary.*

Washington

The annual meeting of the Washington County Medical Society was held at the Redmen's Hall in Dennysville, Thursday, October 20, 1938.

Meeting was called to order at 2.30 p. m. by Dr. W. J. Gilbert, President of the society.

Minutes of the last meeting were approved as read.

Dr. H. H. Best of Pembroke read a paper which had been delivered before the London, England, Medical Society, by his son, Dr. Charles Best of Toronto, Canada. Subject, "Insulin." The paper was a history of the discovery and manufacture of insulin, also of the latest advances in its use. A lengthy discussion followed.

Dr. W. H. Bunker, President of the Maine Medical Association, was the next speaker, bringing before the society both medical and legal questions of vital interest.

After an animated discussion of the questions to come up before the delegates to the next Maine Medical convention, a business meeting was held.

The nominating committee presented the following list of officers for the ensuing year which was accepted by the society:

President: Dr. John T. Metcalf of Lubec.

Vice-President: Dr. P. J. Mundie of Calais.

Secretary-Treasurer: Dr. Oscar F. Larson of Machias.

Censors: Dr. J. A. McDonald of East Machias, Dr. J. L. Murphy of Eastport, Dr. S. R. Webber of Calais.

Program Committee: Dr. John F. Hanson of Machias, Dr. J. L. Murphy of Eastport, Dr. Norman E. Cobb of Calais.

Delegate to Maine Medical Convention: Dr. John F. Hanson of Machias.

Alternate: Dr. James Bates of Calais.

There were 12 members and three visitors present.

At 6.00 p. m. the meeting adjourned and was followed by a banquet at the original Allan House.

Respectfully submitted,
Oscar F. Larson, M. D.,
Secretary.

New Members

Cumberland

B. S. Munro, M. D., Berlin, New Hampshire.

Piscataquis

Burton S. Marsh, M. D., Greenville Junction.

Coming Meetings*

Cumberland

Cumberland County Medical Society, Harold V. Bickmore, Portland, Secretary.

December 9th, Annual Meeting at the Eastland Hotel, 6.45 P. M. Speaker, *Maxwell E. Macdonald, M. D.*, Boston, Massachusetts. Subject: "Emotions and Bodily Changes."

Kennebec

Kennebec County Medical Society, Frederick R. Carter, Augusta, Secretary.

December 15th, Augusta State Hospital, *Dr. A. Warren Stearns*, speaker.

* For more detailed information regarding coming county meetings, write to the County Secretary.

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Necrologies

Lester Lovett Powell,
1875-1938

Dr. Lester Lovett Powell, 63, widely known Portland physician and World War veteran, died suddenly at his home in Portland, September 30, 1938.

Born in Topsfield, Maine, March 24, 1875, son of Andrew and Dorcas Sears Powell, he was graduated from the Maine Central Institute in 1896, from Bates College in 1900, and received his Medical Degree from the University of Pennsylvania Medical School in 1905.

Dr. Powell practiced medicine in Saco from 1906 to 1917. He was overseas, in the service of his country, from 1917 to 1919, and on his return came to Portland where he remained until his death.

He was a member of the Cumberland County Medical Society and the Maine Medical Association.

He is survived by his wife who was Bertha O. True of New Gloucester.

Willis Bryant Moulton,
1862-1938

Willis Bryant Moulton was born on July 3, 1862, at Cornish, Maine, and died in Portland, Maine, on October 8, 1938.

When Dr. Moulton was very young, his family moved to Cape Elizabeth where he attended school. After graduation from Cape Elizabeth High School, he taught at Falmouth and Cape Elizabeth and then entered Bowdoin Medical School from which he graduated in 1883. Following his graduation he practiced medicine for fifty-five years in Portland, and except the first two years his practice was confined to ophthalmology and otology. He attended clinics in this country and studied abroad.

From 1886 to 1892 Dr. Moulton was assistant surgeon at the Maine Eye and Ear Infirmary. In 1892 he was appointed Clinical Instructor in diseases of the eye and ear at Bowdoin Medical School, in 1893 Clinical Professor, and 1904 to 1921 Professor of Ophthalmology and Otology. From 1892 until his death he was a member of the Staff of the Maine General Hospital.

For more than fifty years Dr. Moulton was a member of the Masonic Bodies, the Maine Charitable Mechanic Association, Portland Medical Club and the Maine Medical Association. In 1932 he was made an honorary member of the Portland Medical Club. In 1933 he received a gold medal from the Maine Medical Association in recognition of fifty years' service in his profession. He was a charter member of the Lister and Innominate, two local medical clubs. He also enjoyed membership in the Fraternity Club, a literary organization. In 1898 the degree of A. M. was conferred upon him by Colby College.

Dr. Moulton was a leader in his profession both as a teacher and a clinician. He enjoyed his contact with the medical students and showed a kindly interest in them. In his teachings he always stressed the importance of the relationship of his specialty to general medicine. He was a careful operator with invaluable good judgment—requisites of a skilful surgeon. His reputation in the special department of medicine to which he limited his practice was state-wide, and the results of his labors not only were a credit to himself but to the institutions in which he was interested.

Dr. Moulton was a member of many organizations, but was especially devoted to his friends in the Lister, Innominate and Fraternity Clubs. He had a retentive memory and took keen delight in the discussion of various subjects which constantly came up at their meetings.

In the spring of 1935 he was disabled with a broken leg and this partially incapacitated him for the rest of his life. His death came peacefully at his home while he was reading, a diversion which he greatly enjoyed, especially during his later years.

In June, 1886, Dr. Moulton married Estelle May Cole of South Portland. She died in January, 1937.

Dr. Moulton is survived by three sons, Dr. Albert W. Moulton of Portland; Dr. Bryant E. Moulton of Winchester, Mass.; Dr. Manning C. Moulton of Bangor; and one daughter, Mrs. Margaret E. Morrell of Augusta.

Notices

Scientific Exhibit American Medical Association

Application blanks are now available for space in the Scientific Exhibit at the St. Louis Session of the American Medical Association, May 15-19, 1939. Attention is called to the fact that the meeting is a month earlier than usual, and applications close January 5, 1939. Blanks will be sent on request to the Director, Scientific Exhibit, American Medical Association, 535 North Dearborn St., Chicago, Ill.

Bureau of Health Services for Crippled Children 1939

Clinic Schedule

Rumford: *Rumford Community Hospital*—1.00 P. M. to 3.00 P. M., Wednesday, January 25th, March 29th, May 24th.

Machias: *Washington State Normal School*—1.00 P. M. to 3.00 P. M., Wednesday, January 18th, April 26th.

Lewiston: *Central Maine General Hospital*—9.00 A. M. to 11 A. M., Saturday, January 28th, February 25th, March 25th, April 29th, May 27th, June 24th.

Bangor: *Eastern Maine General Hospital*—1.00 P. M. to 3.00 P. M., Thursday, January 12th, February 9th, March 9th, April 6th, May 4th, June 1st, June 29th.

Portland: *Children's Hospital*—9.00 A. M. to 11.00 A. M. 1.00 P. M. to 3.00 P. M., Monday, January 9th, February 13th, March 13th, April 10th, May 8th, June 12th.

Presque Isle: *Northern Maine Sanitorium*—9.00 A. M. to 11.00 A. M., 1.00 P. M. to 3.00 P. M., Tuesday, May 16th.

Rockland: *Knox County Hospital*—1.30 P. M. to 3.00 P. M., Thursday, February 23rd, June 15th.

Waterville: *Thayer Hospital*—1.30 P. M. to 3.00 P. M., Wednesday, February 1st, March 22nd, May 31st.

NOTE: No Clinic appointments can be made for patients during the last five days prior to the Clinic except for cases who are referred in directly by physicians.

Book Review

"The New-born Infant—A Manual of Obstetrical Pediatrics"

By Emerson L. Stone, M. D., Associate Clinical Professor of Obstetrics and Gynecology, School of Medicine, Yale University; Attending Obstetrician and Gynecologist to the New Haven Hospital.

Published by Lea and Febiger, Philadelphia, 1938. Price, $3.00.

The American child has received a great deal of specific professional attention during the last few decades. Peculiarly enough, however, there seems to have been a certain phase of its childhood which for some reason or other was almost habitually neglected because everybody seemed to be of the opinion that everything is just about as well as it can be with the new infant. The author of this small volume of 290 pages disturbs this apparently comfortable belief in non-interference during the first six weeks of the infant's life. He discovered that somehow neither the obstetrician nor the pediatrician felt that the infant's health and welfare was their concern. The practitioners in both fields were apparently quite at peace with the belief that there seems to be a tendency in the new-born to adapt itself to its new environment in a surprisingly satisfactory fashion in the greatest majority of cases. Actually the more common aspects of new-born pathology seems to be so numerous, in the opinion of the present author, that no one individual could ever hope to obtain first-hand knowledge of all of them in a life-time of medical practice.

The book is divided into thirteen chapters. Each chapter describes a group of aspects shortly and clearly. An attempt is made to outline for the practitioner such problems as the immediate care of the new-born, the physiology and development of the new-born, the nursing care of the normal infant, breast feeding, the pathological aspects of breast feeding, modified feeding, the dietary disorders of infancy, birth injury both cranial and extra-cranial, infections, disorders of the special systems, and the premature infant.

It seems that the large amount of useful information contained in this little book should attract a great many readers from both fields of the medical specialties interested in the new-born child; namely, obstetrics and pediatrics, as well as from the general practitioner who from necessity must possess the information needed for the appropriate treatment of his next case.

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of the
Maine Medical Association

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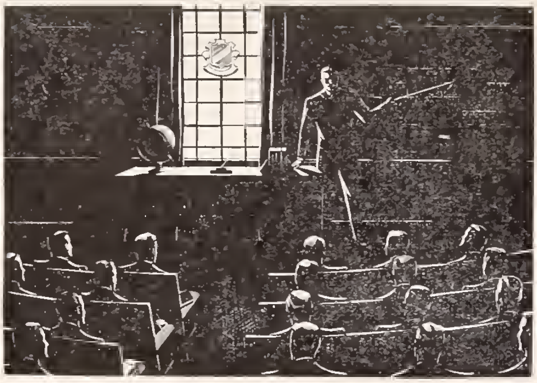

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(1) 1932. J. Amer. Med. Assn. 99, 215 and 301.
(2) J. Amer. Med. Assn. 110, 2150.
(3) Ibid. 110, 703 and 1179.
(4) 1936. U. S. Pharmacopeia, XI Decennial Revision.
(5) 1935. J. Home Econ. 27, 658.
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